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B L A C K D O C T O R S

An Investigation into Aspects of the Training and Career of Students and Graduates from the Medical School of the University of Natal.

PART II : THE GRADUATES

H.L. WATTS

1976.

ACKNOWLEDGEMENTS.

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H.L. WATTS.

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PART II : GRADUATES OF THE MEDICAL SCHOOL OF THE UNIVERSITY OF NATAL

1. INTRODUCTION:

This report is the second one in the series dealing with the various aspects of the research undertaken into the Medical School at the University of Natal. Students, staff, and graduates were covered by the research. In addition, a brief study was made of the beliefs and practices regarding health and ill-health of Indians and Africans in the city of Durban. This report examines graduates of the Medical School. For an overview of the project see the General Introduction to Part I of the Report.

Of the four parts of the research project, the section dealing with the graduates is the most important and the most interesting. After all, any medical school exists to produce graduates, so that it is an examination of the products of the medical school that counts most of all. The proof of the effectiveness or otherwise of any medical school is in the work of its graduates during their medical careers subsequent to graduation.

The research into the graduates presented several challenging problems, and it was not possible to successfully solve all of them. The first problem was how the necessary data were to be collected. The most detailed and revealing picture of Black* doctors would be obtained by participant observation. This means a fieldworker or workers sharing the daily life of a selected range of doctors, and observing all relevant facets of their behaviour over at least several months. Practical aspects concerning fieldworkers, finance, the wide geographical distribution of doctors, and the nature of Black doctors' hospital work or private practice ruled this approach out. Instead a survey type approach was adopted. Participant observation cannot cover past events, so that in any case the graduates would have had to be interviewed. Adopting the survey approach meant that all our data would be obtained by interviewing (or postal questionnaires in the case of doctors too remote for interviewing to be feasible). In an effort to increase the depth of the information obtained, a projective test in the form of incomplete sentences, and likert-type attitudinal scales were used in addition to structural interviewing. Details are given in Appendix B.

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* In this report "Black" refers to Africans, Asians and hybrids ("Coloureds") from South Africa. Where only one race group is involved, the specific individual term is used.

The second problem was how can one measure the effectiveness or otherwise of medical practitioners? In what way can one gauge the skill and ability, and general performance, of graduates of the Medical School? To put it in a nutshell, the Board of the Faculty of Medicine at the University of Natal would like to know what kind of doctors it is turning out, and in order to evaluate its work would like to know how they fare during their subsequent careers. After considerable discussion, the research team came to the conclusion that it is impossible for social scientists who are lay workers in the field of medicine to evaluate the performance of a medical man. Only one doctor can evaluate another, and in any case this cannot be done on the basis of only a brief encounter such as is typical of survey interviews. Perhaps the best way to evaluate any graduate of the Medical School would be to find out how, after a period of being in practice, other doctors around him regard his ability and performance. However, as sociologists we could find no way that was both correct in terms of professional ethics and also was socially acceptable, which would allow us to find out what doctors in a town or district think of any particular individual medical practitioner in practice there. This means that the research project cannot directly answer the question of whether the medical school is turning out "good" or "mediocre" or "inferior" doctors. Instead, what the research does is to give a picture of the job history and experience of a sample of graduates. Their attitudes, and their problems and difficulties as they see them, are portrayed. Their own self image and view in retrospect of the medical school are analysed.

When the fieldwork was started in 1970, the number of graduates from the school amounted to 127 Africans, and 174 Indians and Coloureds on the current medical register. (Race was tentatively established by name). They were scattered across the face of South Africa, Rhodesia, other African countries, and overseas. In terms of cost and time it was out of the question to obtain a sample covering all types. A stratified sample was drawn, and interviews were attempted in Natal, southern Transvaal, and the Transkei. It was also possible, due to the kind offices of Dr. Eleanor Preston-Whyte, of the Department of African Studies at the University of Natal, who at that time was overseas on aabbatical leave, to interview those of the graduates overseas who were in England and Scandanavia. A trip was made specially to the University of Rhodesia, by Kathy Mack to interview graduates in and around Salisbury. Details of the sample are provided in Appendix A. Those graduates in the sample who were beyond the range of our fieldwork centres were sent a postal questionnaire, which was a scaled-down version of the interview schedule. (See Appendix B). All overseas cases

not interviewed were also sent a postal questionnaire.

As will be seen from Appendix A considerable difficulties were experienced in interviewing the sample. A pilot survey showed that not only was the interview schedule long (it seldom took less than three hours and doctors are very busy individuals), but establishing contact with the doctors proved to be as difficult as had been anticipated. After lengthy discussions with the Assistant Registrar for the Medical School and the Dean of the Faculty of Medicine, it was decided not to cut the interview schedule to any substantial extent. The final form of the schedule is shown in Appendix B. In the end, a total of 69 graduates was interviewed, and a further 11 responded to a postal questionnaire. Fifty-nine of the interviews were from South Africa, five from Rhodesia and five from Europe. Out of the 69 graduates, 32 (46%) were African, and all but one of the remainder were Indian. (The one concerned was Coloured). The graduates who responded to the interview ranged fairly evenly from early admittances to the school in 1951 to the most recent graduates at the time of the survey (those who had been admitted to the school in 1964). The largest single group amounting to a third had been admitted to the Medical School between the years 1957 and 1959. Both Indians and Africans covered the broad time span of the period that the Medical School had been in existence.

As there is no evidence of systematic biases in the sample, it is considered that the data are worth analysing.

The interview material and postal results were computerised. In view of the size of the non-response, it was deemed wisest to make no attempt to weight up the replies to give an estimate of the universe as a whole. Therefore the results are presented not as estimates of the universe position relating to all graduates of the Medical School, but as an investigation into 69 graduates of the Medical School, plus 11 others covered by the postal investigation. It is considered that the information will give a fairly good idea of the type of graduates that has emerged from the Medical School of the University of Natal. *The postal survey results will be presented only when they add to or differ from the interview material. (Appendix A gives the distribution of postal cases). Generally the postal results are not different from the interview findings.*

2. CHARACTERISTICS AND BACKGROUND OF THE GRADUATES INTERVIEWED:

The average age of the doctors interviewed during our fieldwork was 35 years. The Africans were slightly older at a mean age of 38 years as against 33 years for the Indians. Eighty-eight per cent of the African

graduates we spoke to were male, and 92% of the Indians were male. Only 9% of the Africans had never married, as against 22% of the Indians. Over four-fifths of the Africans and three-quarters of the Indians were married at the time of the survey.

Typically the average doctor had not yet reached middle age, had been married only once, (three Africans and two Indians had been divorced on one or more occasions), and in the majority of cases had been married by religious and civil ceremony. None of the Africans had been married according to traditional customary-union rites, but three-quarters of them had paid bridewealth (or in the case of women doctors had had bridewealth paid for them). It was intersting to note that amongst the Indians two-fifths of the marriages had also been associated with the payment of bridewealth. While typically the Indians married after their medical training was completed (only 14% had married while still at Medical School), two-thirds of the Africans had married during their medical training. The typical age for marriage was the late twenties.

Three-fifths of the Africans had been born in rural areas (roughly equal numbers having been born in the Bantu reserves and on the other hand a mission reserve), whereas two-fifths of the Africans had been town born. Over four-fifths of the Indians had an urban background. In terms of the part of South Africa where most of the childhood had been spent, the African doctors came from all over the country, including seven interviewed from Rhodesia. The Indians by contrast were almost entirely from Natal, with by far the biggest proportion being from Durban and Pietermaritzburg.

Three-quarters of the graduates had gone to Medical School straight from school - Africans had a larger proportion who had worked first or taken some other degree than Indians. Only two-thirds of the African doctors in contrast to over four-fifths of the Indians went from school straight to the Medical School. Previous jobs were always white-collar work. The average age of entering Medical School was 23 years for Africans and 20 years for Indians. The older age of Africans partly reflects some who worked before entering Medical School, but it also reflects the older age of African matriculants, at least in part due to their culturally deprived home environment. The average age of completing their medical training was 30 years for Africans and 27 years for Indians.

The typical African doctor was Christian. Eighty-eight per cent were Christian with 6% being agnostic and a further 6% atheistic. Whereas the same proportions of Indians were agnostic and atheistic, Christians accounted for only 8%. The largest number (56%) were Hindu, and one-quarter

were Muslim. The Christian background of doctors shows a wide scatter over various denominations.

The Black doctors are active in community affairs. Two-thirds belong to one or more voluntary associations, ranging from sporting and recreational clubs to educational or welfare organizations. (The proportions were the same for Africans and Indians). Three-fifths were office-bearers in one or more organizations.

There seems no doubt that amongst Africans the medical practitioner holds very high(probably the highest) status and prestige, in the community. Amongst Indians the doctor is also esteemed, but his pre-eminent position is challenged by large entrepreneurs who are far less rare than amongst Africans. Doctors' spouses were very largely female, and as one would expect came from white-collar, usually upper white-collar, backgrounds, with medicine and nursing and other paramedical work being prominent. A total of 58% of the spouses had worked in the medical or nursing field prior to their marriage. While there was a scatter of educational levels amongst the spouses, the typical spouse had an educational level well above that for the African or Indian communities in general. The Indians had three times the proportion of African spouses with less than Standard VII education - a reflection of the remains of the *purdah* system amongst Indians.

An examination of the home backgrounds of the doctors shows that two-thirds had a father who was a white-collar worker - in fact over half came from upper-white-collar homes. One-quarter came from upper-blue-collar homes, and less than a tenth came from homes where the father was a lower blue collar worker. In nearly all cases the mother of a doctor was either a housewife or a white-collar worker (usually a teacher or a nurse).

A very interesting finding was that the average educational level of the fathers of African doctors was higher (at Standard IX) than Indians (where the mean level of education for fathers was Standard VI). This may well reflect the fact that amongst the Indians it is possible to go into commerce without having completed one's schooling, and be fairly successful. On the other hand, commerce is a very limited avenue of advancement for most Africans, so that education is perhaps more important. The same pattern applies to the mothers of our sample of graduates - Standard VIII was the average level of education for African mothers, as against only Standard V for Indian mothers.

Typically the African doctor has dependants other than his own wife and children. Only 16% of the African doctors had no dependants apart from their immediate family, as against half of the Indian doctors. There is a fairly wide scatter as far as the relationship of the dependants was concerned. Usually the dependants were one or both parents, and/or siblings.

Nephews or nieces, or cousins were rarer. The form of the dependency very often was not complete dependency, but one where the doctor contributed to the living expenses of the person dependent on him. In only a quarter of the Africans and 17% of the Indians in our sample were their dependants completely dependent on them. In all other cases there were varying degrees of dependency.

In nearly every case the married doctors had their spouses living with them. There was only one case of separation, with a divorce pending. In other cases the separation of the doctor from his spouse was due to either overseas study or further educational training.

Out of the total of 69 doctors interviewed, three were Africans who had left South Africa due to the political situation and/or political pressure. One doctor covered by the postal questionnaire had left for this reason. These doctors would like to revisit South Africa, but would only settle here if there was a change in government policy. Eight of the doctors interviewed were not citizens of South Africa, and had come to the country specifically to obtain a medical degree.

3. JOB HISTORY:

At the time of the interviews two-fifths of the sample of graduates were in hospital service, and a similar proportion were in private practice as general practitioners. Relatively more of the Africans - half - than Indians - only a third - were in general practice. Two of the Africans who were interviewed were engaged in further study, while four of the 11 cases covered by the postal survey were pursuing further study overseas. Seven cases or a tenth of those interviewed combined a general practice with part-time hospital service. None of the graduates interviewed were in private practice as specialists. Table 1 provides details of the job history of the graduates covered by the survey.

Table **1.**

Post-internship job history of a sample of Black Medical Practitioners who graduated from the University of Natal, interviewed during 1970 - 1971.

Job History, giving Sequence of Jobs	No. of Medical Practitioners					
	Africans		Indians		Total Studied	
	No.	%	No.	%	No.	%
1. Hospital/Clinic work only	8	25,0	15	41,7	24	34,8
2. Hospital work; then general practice	12	37,5	9	25,0	21	30,4
3. Hospital work; general practice and part-time health service	2	6,3	4	11,1	6	8,7
4. General practice only	3	9,4	2	5,6	5	7,2
5. Hospital work; then overseas work	3	9,4	1	2,8	4	5,8
6. Hospital work; overseas work; and then general practitioner in South Africa	1	3,1	1	2,8	2	2,9
7. Hospital work; overseas; hospital and part-time general practice in South Africa	1	3,1	-	-	1	1,4
8. Hospital; G.P.; hospital work	-	-	1	2,8	1	1,4
9. Hospital: research; G.P. and part-time hospital work	-	-	1	2,8	1	1,4
10. Hospital; Junior Lecturer; hospital work and part-time G.P.	-	-	1	2,8	1	1,4
11. General practice, later with part-time hospital work	1	3,1	-	-	1	1,4
12. General practice; hospital work	-	-	1	2,8	1	1,4
13. General practice; hospital work overseas; hospital work	1	3,1	-	-	1	1,4
TOTAL	32	100,0	36	100,0	69	99,6

NOTE: The total column includes one Coloured doctor who has worked in hospitals only.

It will be seen from the table that about a third of the graduates had worked all of their career up until the time of the study in hospital and/or clinic work only. (This was true of 10 out of the 11 cases contacted by post). A further approximately one-third had started off in hospital work, and then moved into private practice subsequently. Only five cases, or 7 per cent had been in private practice only since completing their internship. This figure must be considerably lower than the figure for White medical practitioners in South Africa, and reflects the financial difficulties which most Blacks have in setting up a private practice. In fact the typical pattern is for those who are in private practice today to have started off in hospital work and then only subsequently moved into general practice when they were in a position to do so. There are a variety of other permutations in job history. Six cases or about 9 per cent started their careers in hospital work, and subsequently moved into general practice with a part-time continuation of service in provincial or central government health work. Six per cent (four cases) had started in hospital work, and were employed overseas when interviewed. Other permutations of hospital work, and/or general practice, and/or overseas experience, or teaching or research, account for a few of the cases, and need not be commented on.

The average (mean) length of the working career of graduates after completing their internship, up to the time of the interview, was 4,8 years, so that on average the doctors were fairly recent graduates. These doctors had an average of 2,70 employers (counting general practice as one employer where the individual is his own employer), and the mean length of service per employer was two years. The correlation between on the one hand length of career after internship and on the other hand the average length of employment per employer is $r = 0,62$. This means that the longer the overall length of service of a doctor, the longer on average is mean length of service per employer. This shows the process of reducing job mobility, or "settling down" in a particular job after a variety of changes. The co-efficient of non-determination is 0,62, showing that 62 per cent of the variation in mean length of service per employer is not explained by variation in the overall length of service. Other factors influenced job stability, and these would vary from one individual to another, and would almost certainly relate to the specific aspects of the particular job and job satisfaction or frustration.

The average length of service per employer (counting one practice in a particular place as an employer for those in general practice) was 1,40 years for Indians as against 2,73 years for Africans. The sample suggests that Indians seem more unstable job-wise than Africans, and have changed employers at shorter intervals. Why this should be so is a matter for conjecture.

The sample of graduates were asked to indicate the types of problems they experienced in different jobs during their career. The most frequently mentioned problem in the interview and also the postal surveys was that of overwork, with consequently inadequate time for relaxation, study, and other important aspects of a balanced life. It was nearly always hospital staff who mentioned this problem, and this state of affairs was felt to be due to a too high patient: doctor ratio. Some general practitioners commented on the problem of poverty amongst their patients, which took the form both of sometimes inability to pay for treatment, and the depressed conditions of life in the patients' homes. Doctors in rural areas sometimes mentioned the problem of isolation, and being cut-off not only from urban amenities but also from other colleagues.

4. REASONS FOR BECOMING A DOCTOR:

The graduates were asked during the interview why they originally had decided to become a doctor. About a third of the students had been influenced in their decision by what sociologists would term "significant others" - that is, other people who are significant for the individual concerned. In most cases these were either the family or relatives beyond the immediate family circle of the graduate. On occasions a doctor or even a hospital were mentioned as influencing the decision to take up medicine. In about one in six of the cases early experience of illness or death in the family decided the individual to take up medicine. Some of the doctors gave the same reason as the students whom we had interviewed (and reported on in Part I of this report). One-tenth said that they had chosen medicine because it was a profession readily available to Blacks. Another tenth of them stated that medicine was the only good and rewarding profession. The remaining third of the cases gave a variety of reasons.

The reasons given do not differ significantly from those mentioned by the students whom we had interviewed during the course of the study.

5. ATTITUDE OF GRADUATES TOWARDS THEIR TRAINING:

The graduates were asked to look back in retrospect on their training received at the University of Natal, and to comment generally and also in regard to specific aspects of their training. Three-fifths of the sample considered that their training had been good, but had some areas for improvement. A further fifth saw their training as having been of an excellent standard. Only three of those interviewed and none of the cases contacted by mail said that their training had not been good. The remainder

were rather neutral in their attitude towards their training. There was a wide scatter of comments on various aspects of training which could be improved. This lack of consensus suggests that there were no major weaknesses in the training the graduates had received. Details of suggestions for improvement are as follows:

In regard to theory, the major suggestion (made by one-quarter of those interviewed), was that theory should be related more to practical application than had been the case during their training. Only four of the cases felt that the theory had been inadequate or poor. The suggested changes ranged widely, with no major points being repeated by a substantial number of the doctors.

Just over half saw their laboratory practical work as having been very good and not needing any change in approach. However, one-quarter did state that students must be shown the relevance of their practical work for clinical situations. They felt that during their training they had not always perceived the full significance of the laboratory work for their subsequent clinical training.

Seven-tenths of the doctors were satisfied with the clinical training they had received. There was a wide variety of comments. The only comment made by more than one or two individuals was the statement by 9% of the cases, that clinical work should be given right throughout the course of training, from the earliest years in medical school.

As far as the balance between theory, laboratory work and clinical work was concerned, over half the Africans and a third of the Indians saw the balance that was held by the Medical School during the time they were trained as satisfactory. Five (16 per cent) of the Africans had wanted more laboratory work from third year onwards, while a fifth of the Indians felt that there was not enough time for relating theory and laboratory work to clinical aspects of being a doctor. For the rest there was a wide scatter of responses.

Two-fifths of the doctors covered by the survey saw the course sequence during their training as satisfactory. One in eight wanted the pre-medical courses dropped. (It was interesting to note that as small a figure as this mentioned pre-medical training, as only one-tenth of the students felt that the pre-medical year is a waste of time (see p.16, Part I of the Report).) There is no real consensus in regard to recommendations for changing course sequence. As far as changes in course content were concerned, one in six felt that inadequate time had been given during their training to sub-departments. Other comments were made by four or less of the students in each case, and therefore need not be noted.

Students throughout the world are commenting critically on the examination system in universities. It was therefore very interesting to note that looking back on their student days, almost one half of the students saw the exam system under which they had been trained as satisfactory. Those who had suggestions to make about improving the examination system again varied widely in their views. One in six wanted regular testing during the year, rather than at the end of the year.

The graduates were questioned about the teaching methods that they had experienced as students. Once again there was a lack of clear-cut recommendations for change. One in five wanted greater emphasis placed on audio-visual aids in teaching, while one in eight felt that greater supervision of students, particularly in certain departments, was desirable. A further one in eight wanted greater use of small group methods in teaching, and in this no doubt they were echoing the views of many of their lecturers.

Just over half of the doctors felt that their teachers had been good teachers, helpful and co-operative. One in six felt that while their teachers had been good in some departments, they were poor in others. Less than one-tenth saw their teachers as having been unapproachable or impersonal, but nonetheless academically sound. It is interesting that two-thirds of those who commented thus were Africans, suggesting that perhaps they may have had greater need for emotional support during their training than Indian students. One in eight of the doctors we spoke to viewed the staff under whom they had been trained with a jaundiced eye, and had no hesitation in regarding their teaching as "bad".

An important aspect of the training of any student is the workload. Looking back to their student days, only one-third of the medical graduates saw the load imposed on them when they were students as having been manageable. The majority therefore regarded the amount of work they were expected to do as having been too great. One-sixth commented that the workload could be made manageable if more of it was spread over into the "easy years" of study - the preliminary pre-medical year, and the fourth year. Physiology was singled out as the subject with the heaviest load, and in this the graduates had views similar to many of the present-day students. (See p.17, of Part I.) The heavy workload was seen as resulting from certain subjects, for only 6% of the Africans and 22% of the Indians saw all subjects as having involved a heavy workload.

The relations which the graduates had had with their teachers during student days were generally seen as having been good. It is encouraging to note that only 6% saw the student-teacher relationship as having been strained because of race factors. In contrast to this, over a quarter were quite emphatic that most of the administrative staff - especially the more

junior grades of clerks and typists - were rude, or unfriendly, or unhelpful towards the students when they had been at Medical School. This echoes a complaint of a not insignificant proportion of present-day students, and this point has been commented on in Part I of this report dealing with students (p.25).

A third of the doctors felt that there had been important omissions in the training they received as students. The most frequently mentioned omissions were aspects relating to the work of a general practitioner. In all, over one in four of the graduates commented along these lines. However there was no over-all consensus as to just what subjects should be taught in greater detail with a view to assisting in the training of general practitioners. The topics concerned ranged from social and preventive medicine, and paediatrics, to psychiatry, pharmacology and laboratory procedures. One in five felt that greater training should have been given in the sub-disciplines of dentistry, skin diseases, ears, nose and throat diseases, and ophthalmology.

Incomplete sentences were also used to determine reactions towards the Medical School. (See Appendix B). Most of our sample of graduates viewed the Medical School favourably, and looked back with pleasant memories to their student days.

6. FINANCIAL ASSISTANCE

Some of the graduates saw a need for change in the financial assistance provided to students. Three-tenths felt that there should be greater financial assistance from the State, and also from other sources. Emphasis was placed on the need for more free bursaries where there was an outright grant for a student, and not a bursary/loan where part of the money had to be repaid subsequent to graduating. One in five felt that the bursaries were inadequate to meet the expenses which students had to face, and argued for an increase in the value of bursaries. To put the problem another way, only 9% of the sample of graduates interviewed were explicitly of the mind that the financial assistance to students was adequate with no need for improvement whatsoever. One in eight went so far as to say that the bursaries had been unfairly allocated, not infrequently being given to those who did not deserve or need them. It was only Indian doctors who made this point.

7. MEDICAL SCHOOL RESIDENCES

Only 7% of the doctors we spoke to saw the Medical School residences at Wentworth as being good. The problems mentioned were those which we found present-day students also complained about. Complaints concerned overcrowding in rooms, poor rooms, unsatisfactory food, transport difficulties with the residence too far from the Medical School, the bad siting of the residence in that it was situated on the edge of an industrial area, and its general isolation. (See pp.27-29, Part I of the report).

8. RELATIONS WITH FELLOW STUDENTS

Two-thirds of the doctors we spoke to saw the relations with fellow students during their training as having been either generally good or even very good. None saw student relations as being bad, but some were concerned about the tendency for Africans on the one hand and Indians and Coloureds on the other to stick together and not make many if any friendships across colour lines. Some referred to what they described as an "apathetic" relationship between the races without much concern for people of another race.

9. THE MEDICAL SCHOOL OF THE UNIVERSITY OF NATAL IN CONTRAST TO OTHER MEDICAL SCHOOLS

Graduates have far greater opportunity to mix with the products of other Medical Schools than do students, and therefore it was regarded as important to get some idea how the graduates of the University of Natal saw other medical schools. Two out of every five felt that the Medical School at this university compared very favourably with other medical schools, while a further one in four saw it as comparing favourably. Only 4% of those interviewed and none of the postal cases saw it as comparing poorly, while the remaining informants either felt that it was much of a muchness, or could not make up their minds.

Over half of the interview cases and 10 out of the 11 postal questionnaire cases were quite emphatic that the Medical School compared either favourably or very favourably with overseas medical schools. (Four of the 11 postal cases had also studied overseas, and one in Rhodesia and one in Zambia).

In terms of what the graduates said therefore we may conclude that most of the graduates of the Medical School saw their alma mater in a favourable light. In addition, however, to asking the graduates to comment verbally on the Medical School, they were asked to indicate by means of a pencil and paper likert-type test how they rated the Medical School. Appendix B shows the form which the graduates were asked to use to indicate their rating of the

Medical School. By way of comparison they were also asked to rate another medical school in the country - the predominantly "White" medical school of the University of the Witwatersrand. Each polar item in the test can be scored from 1 (being the most positive score) through 4 (being a neutral score) to 7 (being the most negative score). Average scores were worked out for the sample, and Table 2 below compares the mean scores for the University of Natal Medical School with that for the University of the Witwatersrand.

Table 2.

A Comparison of the attitudes of University of Natal Medical Graduates towards their own Medical School, and the Medical School of the University of the Witwatersrand.

Polar Characteristics	Mean Scores	
	University of Natal	University of the Witwatersrand
Good - Bad	2,2	2,3
Important - Unimportant	2,1	2,2
True - False	2,1	2,7
Successful - Unsuccessful	2,1	1,8
Kind - Cruel	3,2	3,0
Active - Passive	3,1	2,4
Problem Free -Problem Ridden	5,1	4,5
Organized - Disorganized	2,8	2,3
Full of Ideals-Lacking Ideals	3,6	2,5
Realistic - Unrealistic	3,0	3,0
Competent - Incompetent	2,2	2,2
Unprejudiced - Prejudiced	3,8	3,6
Fair - Unfair	2,8	3,0
Progressive - Conservative	3,4	2,7
Best - Worse	2,9	2,7
Clever - Stupid	2,7	2,6
Trustworthy - Untrustworthy	2,6	2,7
Satisfied - Dissatisfied	3,1	3,2
Mean Score for all items	2,9	2,7

NOTE: The responses were scored on a seven-point scale, from 1 (representing the most positive position) to 7 (representing the most negative position) on the polar characteristics. A score of 4 represents a neutral mid point.

See Appendix B for the form of the test used.

The over-all score for the 18 items for the University of Natal Medical School was 2,9 against a fairly similar figure of 2,7 for the University of the Witwatersrand. This shows that generally both Medical Schools were viewed in a fairly favourable light, with a slight edge in favour of the University of the Witwatersrand. The University of Natal scores higher on the true-false polarity, than the University of the Witwatersrand. This particular item is difficult to interpret, but it may mean that the graduates saw their own Medical School as being rather more true to basic medical ideals. On the other hand, the Medical School at the University of the Witwatersrand was seen as more successful, kinder, more active, less problem-ridden, better organized, fuller of ideals, and more progressive than the graduates' own Medical School. Figure 1 graphs the mean scores, and shows the profile of the two Medical Schools.

We can conclude that on the whole the graduates see their own Medical School in a favourable light, but in certain respects see the Medical School at the University of the Witwatersrand in a rather more favourable light. This Medical School is an older one than the Durban one, and it is at a larger university. It also happens to be a Medical School which is predominantly White in student composition. (African, Asian and Coloured students need special permission from the Minister of National Education to attend the University of the Witwatersrand Medical School, and Africans in particular are encouraged to come to the University of Natal). This factor may influence the perception of that Medical School by Natal graduates.

The scores for Africans in contrast to Indians amongst the graduates were examined. There is no important difference between the scores for the two groups as far as the image of the Medical School at the University of the Witwatersrand is concerned. However in regard to the University of Natal Medical School, Indians see the Natal school in a less favourable light. The main areas of difference are that the Indians see the Medical School as somewhat more disorganized, somewhat lacking in ideals, somewhat less realistic, and more bigoted, as well as more conservative and worse generally than do the Africans. Table 3 provides details of the scores.

FIG. 1.

THE IMAGE GRADUATES HAVE OF THE MEDICAL SCHOOLS OF THE UNIVERSITY OF NATAL, AND OF THE UNIVERSITY OF THE WITWATERSRAND

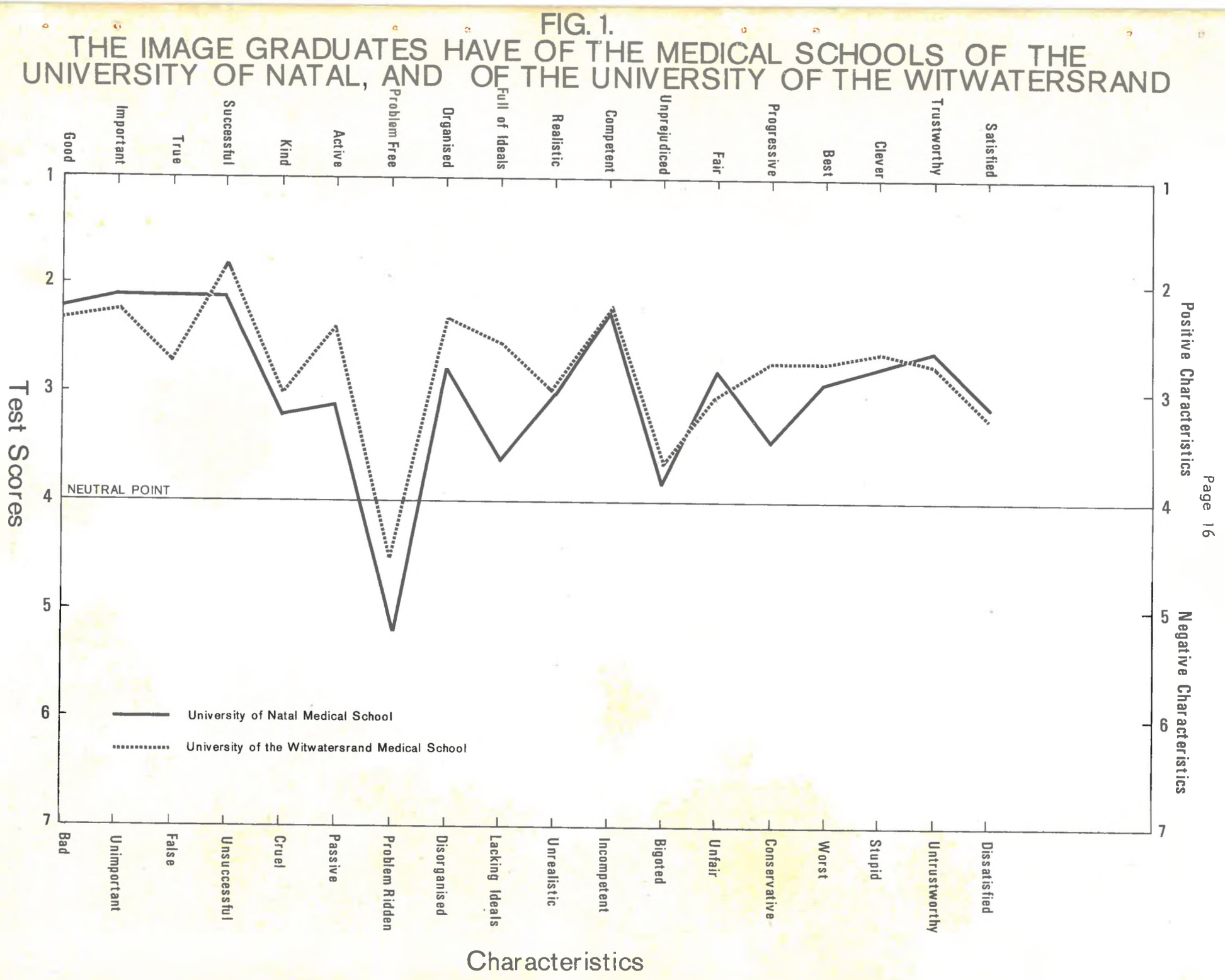


Table 3.

A Comparison of the Attitudes of African Graduates in contrast to Indian Graduates towards the University of Natal Medical School.

Polar Characteristics of the Medical School	Mean Scores	
	Africans	Indians
Good - Bad	2,3	2,2
Important - Unimportant	2,1	2,0
True - False	1,9	2,3
Successful - Unsuccessful	2,2	2,1
Kind - Cruel	3,1	3,3
Active - Passive	3,0	3,2
Problem-Free - Problem-Ridden	5,2	5,1
Organised - Disorganised	2,4	3,1
Full of Ideals-Lacking Ideals	3,0	4,1
Realistic - Unrealistic	2,6	3,3
Competent - Incompetent	1,9	2,4
Unprejudiced - Bigoted	3,5	4,1
Fair - Unfair	2,7	2,8
Progressive - Conservative	3,0	3,8
Best - Worst	2,6	3,1
Clever - Stupid	2,7	2,8
Trustworthy - Untrustworthy	2,7	2,6
Satisfied - Dissatisfied	2,8	3,3
Mean Score for all items	2,8	3,1

(See the Note below Table 2)

10. PROBLEMS ENCOUNTERED AT THE MEDICAL SCHOOL:

Graduates were asked to cast their minds back to their student days, and talk about the problems which they encountered while they were students at the Medical School. Half of them could not remember having had any personal problems, and those who did report problems in nearly all cases had not sought help from the staff, regarding the problems as something to sort out either with relatives or friends. However, in response to further questioning, two out of every five felt that something should be done to help students with personal problems. Two-fifths suggested that a full-time qualified student counsellor be appointed to the Medical School, whilst one-fifth suggested that each student should be allocated to a member of staff who would become his or her counsellor. The members of staff concerned should have had some training in counselling, so that they could advise and assist students who turn to them.

Financial problems were the most frequently mentioned form of problem. Only one in three stated that they had had no financial problems while they were students. (Only one postal case said he had financial problems as a student, suggesting this group tended to be better off financially than were the average graduates). Those who did turn to either academic or administrative staff for help by and large felt that the help they received was effective. As far as suggestions for helping future students with financial problems were concerned, a quarter of the graduates pleaded for more bursaries and loans, while one in eight pleaded for an increase in the value of bursaries and loans. Fourteen per cent suggested the creation of a fund from which students could borrow whenever the need arose.

Half of the graduates remembered having had academic problems, and the sources of help to which they turned ranged from academic staff to friends or relatives. Only one of the students who had approached a member of staff felt that he could have been helped more than was the case, which is encouraging. From the replies it is obvious that most of those students who had academic problems battled through themselves without approaching members of staff.

11. INTERNSHIP:

We move from the student days of the graduates to the internship they served after graduating from the university. By far the majority (amounting to 71% of the sample) served their internship at King Edward VIII hospital in Durban. While the internship period was formally one year,

three-fifths of the graduates stayed on longer at the hospital at which they had served their internship in order to get additional experience. The mean period of stay at the hospital concerned was 1,9 years. Incidentally, this figure fits in well with the recently revised regulations for internship requiring that a period of two years should be served by interns.

All of the graduates were in fact fairly satisfied with their relations with the fellow interns they met, while three-fifths felt that senior staff in hospitals where they had worked had good relations with them and were helpful. Some pointed out that relations with senior staff varied from department to department, and only one-tenth reported that they had experienced racial prejudice during their internship, as far as the senior staff were concerned. As far as the nursing staff were concerned, just under a half reported that the attitude of the nursing staff towards them when they were interns had been good. Ten per cent commented that White nurses were sometimes a bit bossy and resented taking orders from Black doctors, while another 10% stated that while the nursing staff had had good relations with them, they tended to give advice to the intern and play the role of someone who knew better.

The typical problems of interns were seen as overwork by almost half of the doctors we spoke to. The only other typical problem mentioned was difficulty with elementary surgery and the lack of senior tutors to supervise interns doing operations.

The informants were questioned as to the ideal length they thought an internship should be. Two-fifths thought it should be one year (as in fact it was at the time they were interviewed), two-fifths thought it should be two years, and an eighth felt it should be a year and a half. Thus the majority saw one year as being too short. Questioned about the content of an internship, there was a wide range of ideas, so that it is impossible to make an overall recommendation based on the experience of our informants.

In collecting the reactions of our sample of informants to their internship, use was made of a likert-type scale to measure their image of the hospital where they trained. Each doctor was asked to fill in a page with polar characteristics for the "hospital where I trained". Appendix B provides a copy of the form used. The scores can range from 1 (representing the most positive evaluation) to 7 (representing a highly negative evaluation). A score of 4 represents a more or less neutral mid-point between positive and negative evaluations. Overall, taking all items combined, the Africans were slightly more positive in their evaluations of the hospital where they trained, with a mean score of 3,2. The corresponding score for Indian doctors was 4,2. These figures which are fairly neutral mask some strong positive and negative feelings. Table 4 provides mean scores for the various items, which are graphed in Figure 2.

FIG. 2.
IMAGE OF THE HOSPITAL AT WHICH THE INFORMANT WAS AN INTERN

Table 4.

Mean Scores for the image of the "Hospital where I trained"

Polar Characteristics	Mean Scores		
	All Cases	Africans	Indians
Good - Bad	2,6	2,3	2,8
Important - Unimportant	1,9	1,9	1,9
True - False	2,8	2,5	3,0
Successful - Unsuccessful	2,6	2,3	2,8
Kind - Unkind	3,9	3,3	4,3
Active - Inactive	3,4	2,9	3,8
Problem-Free - Problem-Ridden	6,1	5,8	6,4
Organised - Disorganised	4,3	3,5	4,9
Full of Ideals-Lacking Ideals	4,6	3,5	5,4
Realistic - Unrealistic	3,9	2,8	4,9
Competent - Incompetent	3,3	2,7	3,9
Unprejudiced - Bigoted	4,6	4,3	4,9
Fair - Unfair	4,0	3,4	4,6
Progressive - Conservative	4,3	3,6	4,9
Best - Worst	3,9	3,2	4,5
Clever - Stupid	3,7	3,4	3,9
Trustworthy - Untrustworthy	3,6	2,9	4,1
Satisfied - Unsatisfied	4,4	4,0	4,9
Overall Mean Scores for all items	3,76	3,24	4,22

The graphical profile for Indian and African doctors' opinions of their training hospital follow the same shape, but with only one exception the Indians are considerably more critical of the hospital where they trained than the Africans. Generally the Africans see their training hospital in a favourable light, except that they saw it as being problem-ridden, and with a certain amount of prejudice present. They did not see their hospital as either particularly satisfactory or unsatisfactory. On the other hand while

the Indian doctors saw their hospital as being good, important, true, and successful, they saw it as not particularly active or competent, and had a serious negative view of it in terms of it being problem-ridden, disorganized, lacking ideals, unrealistic, bigoted, unfair, conservative, certainly not the best, and rather unsatisfactory. There is in fact a surprising depth of negative feeling amongst Indians revealed by this graph. Whether this is due to the Indians in fact being more critical, or rather more outspoken and honest in their assessments than the African doctors, it is not possible to say.

12. TYPICAL PROBLEMS ENCOUNTERED BY THE DOCTORS IN THEIR CAREER:

An attempt was made to get some idea of the typical problems encountered by the doctors in our sample. The most frequently mentioned problem pertaining both to the hospital medical officer and also to the doctor in private practice was overwork.

Thinking of hospital work, discriminatory pay was mentioned by a sixth of the informants. (It must be pointed out that at the time the field-work was undertaken, revised scales for medical officers in provincial hospitals had been published, and the discrimination between White and Black doctors had caused a considerable amount of frustration and bitterness amongst Black doctors, and the whole issue was widely ventilated in the public press. The issue therefore was a particularly live one, but at the time of writing this report in 1975 is not an issue attracting public attention. It is a problem which has not yet been solved). Other problems mentioned as relating to a hospital medical officer were the burden of administrative duties and supervision, which often left little time for doctoring; sometimes a lack of communication with the hospital administration; and the shortage of hospital beds which meant the turning away of patients and early discharge of patients who ideally should have been hospitalized for a longer period.

As far as private practice was concerned, apart from overwork the most frequently mentioned serious problem was the poverty and ignorance of patients. Not infrequently patients could not afford the full facilities that really should be made available to them; and they sometimes could not pay the doctor's bill. Another problem was the lack of access to a private hospital where a doctor could admit his own cases and care for them. Also mentioned was the problem encountered by general practitioners when they referred their patients to provincial hospitals for treatment. Unless the doctors concerned were also on the staff of the provincial hospital they were not permitted to follow up their patients personally, and they said they sometimes found difficulty in finding out what had happened to the patient.

The traditional belief in regard to medicine of Africans and Indians, on occasions was also mentioned as creating various problems in the scientific treatment of cases by doctors.

A question put to the doctors as to whether they had any suggestions about the ways in which the Medical School could prepare future doctors for the type of problems they themselves had encountered, produced a fairly wide scatter of responses. A quarter felt that the problems were of such a nature that medical school training could not help. Eleven per cent made the interesting suggestion that medical training should include some form of "apprenticeship" to a general practitioner, so that the students can have some idea before they graduate of how to run a general practice, and an idea of the types of situations and problems which are typical of general practice. A further 11% felt that fuller teaching on the wards was desirable, and in order to achieve this there should be more ward staff.

After a slightly different question, namely to what extent the Medical School had prepared them to face the most important problems they had encountered since graduation, only 9% replied that they had not been prepared by the Medical School, but could and should have been. Once more this points to a positive image of the Medical School amongst most of the graduates.

Sections 16 and 17 report similar findings, obtained later in the interview. They corroborate these results. All graduates who were interviewed (in contrast to those who were given the postal questionnaire) were given incomplete sentences to fill in. By these means it was planned to obtain depth material in regard to their attitudes and opinions. The form of incomplete sentences used is shown in Appendix B.

Incomplete sentences often reveal the problems subjects face. Generally there was wide variation in the completed sentences, and the results did not reveal a marked consensus about problems. This is good, as it points to the absence of widely shared serious problems.

Apart from individual responses, there were two main themes which emerged, (although they were not expressed by a large number of the subjects interviewed). The first theme was, as expected, the problems and satisfactions of a medical career. Long hours of work (especially amongst general practitioners) the pressures and tensions of a medical career, overcrowded hospitals, and the poverty and ignorance of patients were mentioned again and again. Also mentioned were the satisfactions and rewards (psychological and economic) of medicine.

The other theme which recurred was a desire to see an end to discrimination, social injustice and prejudice in South Africa, and instead to have equal opportunity, freedom of movement and free choice of jobs for all. This again was expected. Black doctors are professionally part of a

Western occupational elite, but socially are restricted to poorly educated, non-Western groups. They are marginal men and women, and expressions of this frustrating position were anticipated, and in fact found in the replies.

13. POSITIONS YIELDING SATISFACTION OR FRUSTRATION:

The doctors interviewed were questioned about what position or positions which they had held since qualifying, had yielded them the greatest personal satisfaction. A third stated that being a medical officer in the department of their own choice in hospital was the position which had yielded them the greatest satisfaction. An eighth mentioned being registrar in a hospital, and a further eighth mentioned being a medical officer in a small hospital. One-fifth stated that being a general practitioner was the position which yielded them the greatest satisfaction. Reasons for obtaining personal satisfaction varied widely. Some of those who were medical officers or registrars reported that their senior status allowed them somewhat more time, both for studying and for relaxation, and also they found that the responsibility and authority was rewarding. Being in a hospital with equipment which most general practitioners could not afford, and/or with colleagues to consult, were other reasons mentioned by those in hospital service. Some also mentioned the congeniality of a career with colleagues as being satisfying. One of the main reasons mentioned by general practitioners on the other hand for obtaining personal satisfaction was being one's own boss, able to make one's own decisions in regard to the treatment of patients and the actual working conditions. The rather more personal contact with patients, whereby the G.P. becomes a family doctor is another source of satisfaction. The status in the community and influence is a further source of satisfaction, while some felt that their major source of satisfaction was quite simply restoring health to those who were ill. In some of the bigger hospitals the opportunity to work on certain wards only with a particular kind of case (say obstetrics, or medical or surgical wards) yielded satisfaction.

Only one in eight of the doctors reported that they had not suffered any particular frustration or set of frustrations during their medical career. Overwork mentioned by three-fifths of the doctors was the most frequently reported source of frustration. A fifth referred to the social conditions of extreme poverty and ignorance affecting so many of their patients about which the doctor could do little or nothing. A tenth had been frustrated by the difficulty of following up patients whom they had sent to hospital, and who had thus become hospital patients. A further tenth had been frustrated by the discriminatory pay structure in the government hospitals.

14. QUALITIES OF AN IDEAL DOCTOR:

The ideal doctor, in terms of the opinions of the graduates, is first and foremost kind and understanding (these characteristics were mentioned by 50% of the sample). He is professionally competent (mentioned by 46%) and dedicated and hard working (mentioned by 42%). Other characteristics were mentioned by a smaller proportion of informants. Being thorough, and putting the patients first was mentioned by a third of the graduates, while a fifth mentioned the quality of being able to relate well with the patient. Finally, in sixth place was the quality of being approachable, mentioned by one in eight. Being approachable and being able to relate well to patients are probably two aspects of the same basic quality, and this then was mentioned by a total of one-third of the doctors. Questioned further, most felt that the image they had of an ideal doctor was not significantly different from that which they had before entering Medical School. Of course the whole problem was accurate recall of views held possibly a decade or more prior to the interview arises in this case, but we have no way of knowing exactly what ideas the doctors had before they started their training. A fifth did report that before entering Medical School they had seen a doctor either as a kind of super-human "cure-all" or an "infallible god", and that this view was lost once they came to grips with the realities of medicine. A third felt that the training they had at university had reinforced their original conception of the ideal doctor while one-tenth felt that their training had made them realize how necessary and also how difficult it was to acquire the ideal characteristics they ascribed to a doctor.

On the whole the doctors we spoke to were not very critical of their colleagues or superiors, when comparing them with the ideal they had of the ideal medical practitioner. Only 11% felt that very few of the hospital superiors conformed to their ideal doctor, while one-sixth felt that colleagues in general practice fail to conform to their ideals by being superficial and mercenary. This suggests that the doctors we spoke to had not become cynical, perhaps except for a few isolated individuals. Not only did they subscribe to ideals relating to the practice of medicine, but they also felt that their colleagues in most instances did conform to some extent with this ideal pattern.

15. IMAGES OF DOCTORS FROM VARIOUS RACIAL GROUPS:

Appendix B shows the likert-type pencil and paper tests used to obtain the images the graduates had of White doctors, Indian doctors and

African doctors. The manner in which these scales were applied is described in Appendix B. Tables 5 and 6 below give the mean scores obtained for the various items. Figures 3 and 4 portray the results graphically, and give profiles of attitudes towards various types of doctors.

Starting with the African graduates, Table 5 shows that whereas overall they rate African and White doctors at about the same level, with a mean score of 3,1 and 3,2 respectively, they see Indian doctors slightly less positively at a mean score of 3,5. A glance at Figure 3 shows that these overall averages mask important variations. The African graduates see African doctors as being more good, important, true, kind, realistic, competent, fair,progressive, and trustworthy than either White or Indian doctors. They also see African doctors as being far better in an emergency than White doctors, or Indian doctors who are rated lowest on this point. On the other hand, they see African doctors as being the most problem-ridden of all the doctors, and also the most dissatisfied. One major negative feature which they see as a characteristic of White doctors is prejudice, while in regard to Indians the feature picked out is being problem-ridden (although they do not see this to the same extent as they see the item applying to African doctors). Of the three types of doctors, Whites are seen as being the most successful, the most active and problem-free, the most organized and full of ideals, and the most satisfied. The general trend is that the African graduates tend to see African doctors in a somewhat more favourable light than either the Indian or White doctors.

Turning to Indian graduates, we find that the mean scores for the opinions they have of African, White and Indian doctors are about the same. Again as with the African graduates, Figure 4 shows important variations which these grand mean scores mask. The major negative feature of Indian doctors is seen as being problem-ridden, and to a lesser extent dissatisfied. They are seen as being better in an emergency than White or African doctors, and also more responsible and more fair. White doctors are seen as being the most successful of the three kinds, the most active, the most problem-free and most organized, and also the most idealistic. However on this latter point the differences are not large. The major negative feature of White doctors is seen as prejudice. African doctors are seen as being more problem-ridden than either Indian or White doctors, and also as being most dissatisfied. It was surprising to see the Africans being regarded as better, more important, truer, and more competent than the other doctors, as well as cleverer and more trustworthy, but unfortunately the interview did not allow probing of these findings, which are the result of average scores computed long after the interviews were complete.

Table 5.

Mean Scores of African Doctors Reflecting their Image of African, White and Indian Doctors.

Polar Characteristics	Mean Scores for Doctors		
	African	White	Indians
Good - Bad	2,6	3,2	3,3
Important - Unimportant	1,9	2,6	2,8
True - False	2,3	3,3	3,2
Successful - Unsuccessful	2,8	2,5	2,6
Kind - Cruel	2,5	3,5	3,5
Good in an emergency - Not good	2,3	3.1	3,4
Active - Passive	3,0	2,7	3.1
Problem-free - Problem-ridden	5,8	3,4	4,7
Organized - Disorganized	3,7	2,9	3,1
Full of ideals - Lacking ideals	3,3	3,1	3,3
Realistic - Unrealistic	2,9	3,9	3,6
Responsible - Irresponsible	2,9	3,1	3,6
Competent - Incompetent	2,4	2,6	2,9
Unprejudiced - Bigoted	3,4	4,4	4,3
Fair - Unfair	2,4	3,5	3,6
Progressive - Conservative	3,0	3,5	4,1
Best - Worst	3,2	3,6	3,4
Clever - Stupid	3,1	3,0	-
Trustworthy - Untrustworthy	2,6	3,8	-
Satisfied - Dissatisfied	5,0	2,2	3,9
Overall Mean Score for All Items	3,1	3,2	3,5

NOTE: A score of 1 represents the most positive value, 7 the corresponding negative or polar value, and 4 a neutral point on the seven point scale.

Table 6

Mean Scores of Indian Doctors, Reflecting Their Image of African, White and Indian Doctors

Polar Characteristics	Mean Scores for Image of		
	African	White	Indian
Good - Bad	2,4	2,6	2,7
Important - Unimportant	1,8	2,6	2,6
True - False	2,7	3,5	3,0
Successful - Unsuccessful	2,4	2,3	2,8
Kind - Cruel	3,1	3,5	2,8
Good in an emergency - Not good	2,6	3,4	2,4
Active - Passive	2,7	2,5	3,2
Problem-free - Problem-ridden	5,8	3,0	5,0
Organized - Disorganized	3,5	2,9	3,4
Full of ideals - Lacking ideals	3,4	3,1	3,2
Realistic - Unrealistic	3,1	3,8	3,3
Responsible - Irresponsible	2,9	2,7	2,5
Competent - Incompetent	2,1	2,9	2,5
Unprejudiced - Bigoted	3,9	4,9	3,6
Fair - Unfair	3,2	3,8	2,9
Progressive - Conservative	2,9	3,4	4,4
Best - Worst	3,2	3,3	3,1
Clever - Stupid	2,4	2,8	-
Trustworthy - Untrustworthy	2,5	3,4	-
Satisfied - Dissatisfied	5,0	2,6	4,3
Overall Mean Score for All Items	3,1	3,2	3,2

NOTE: A score of 1 represents the most positive value,7 the corresponding negative or polar value. A score of 4 is the neutral mid point on the seven point scale.

FIG. 3.
IMAGE AFRICAN DOCTORS HAVE OF AFRICAN, WHITE AND INDIAN DOCTORS

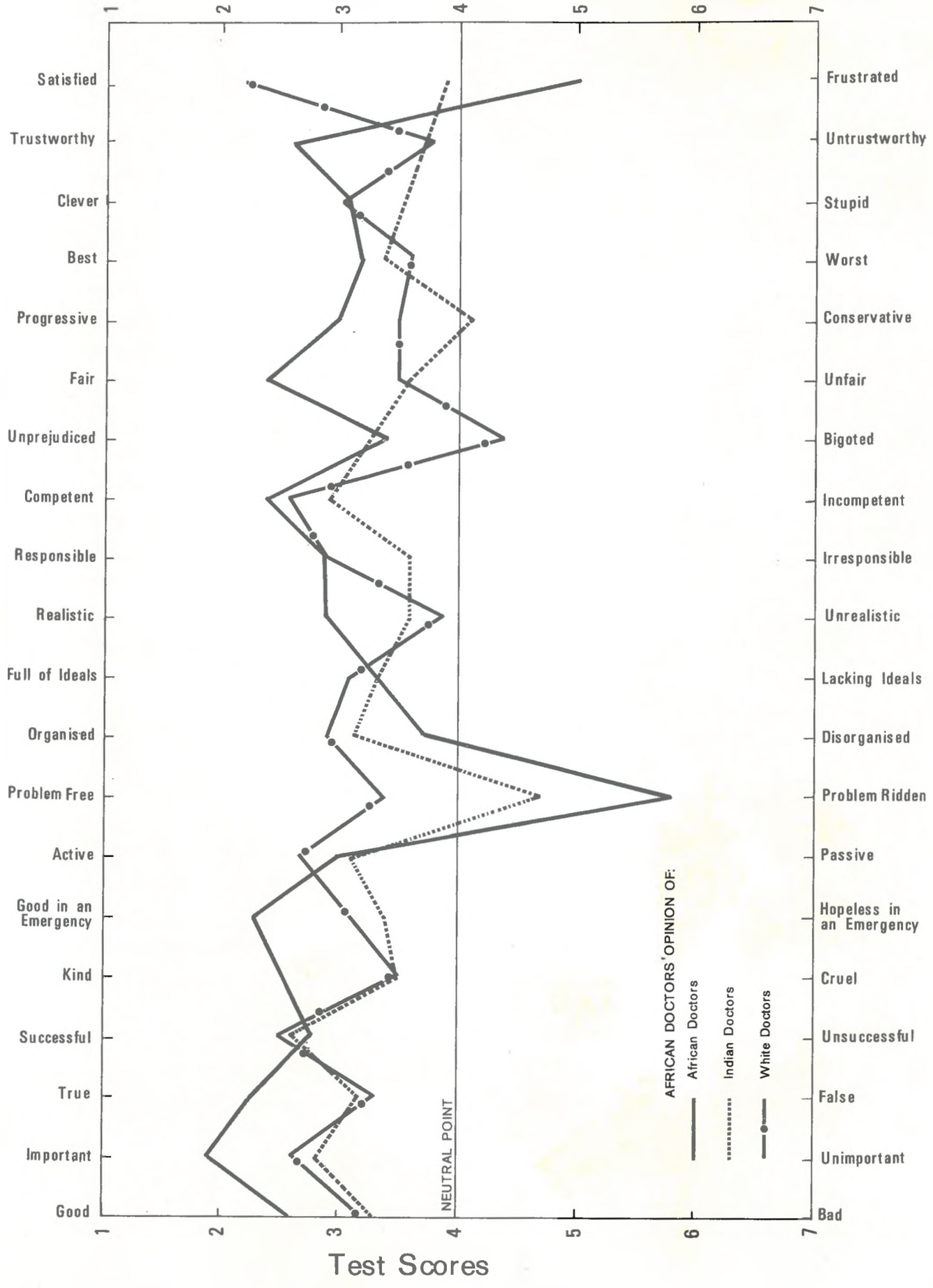
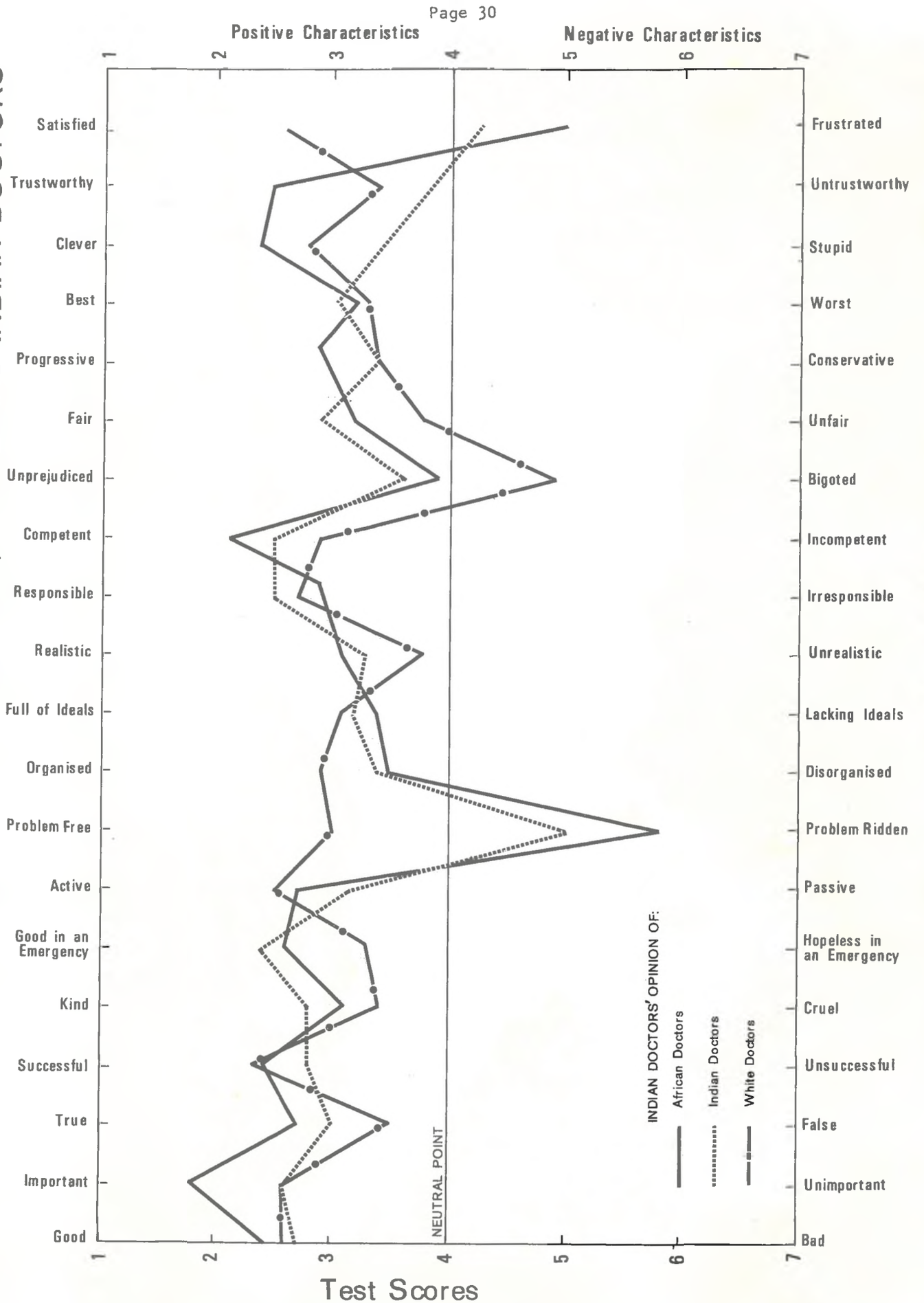


FIG. 4.
IMAGE INDIAN DOCTORS HAVE OF AFRICAN, WHITE AND INDIAN DOCTORS



Overall African and Indian doctors are given much the same profile, although there are differences in scores as has been pointed out. Figure 4 shows that on the first half of the items White doctors are in many instances seen differently from Indian and African doctors.

To sum up, whereas the African graduates tended overall to see African doctors in a more favourable light than either Indian or White doctors, this was not true of Indian graduates.

16. DETAILS FOR THOSE IN PRIVATE PRACTICE.

Just over half (54%) of the doctors whom we interviewed were in private practice at the time of the survey. The average number of years in private practice was short, with the mean of 3,7 years. Half of the doctors had been in private practice for shorter than two and a half years. In other words most of the doctors we spoke to had not been in private practice for very long. The most frequently mentioned reason for deciding to enter private practice was in order to earn more money. The associated reason was the discriminatory pay in hospital service, whereby Black doctors earned significantly less than Whites. One-quarter regretted their decision, the rest were more or less satisfied with the decision they had made to enter private practice. The most frequently mentioned frustration experienced in private practice, mentioned by about a third of the doctors, was being on call 24 hours a day. About one-fifth were frustrated by having patients who finally come to a doctor too late, after traditional medical avenues have failed, and their case is beyond cure. A similar proportion mentioned being frustrated by the social problems of poverty, ignorance and malnutrition affecting so many of their patients. One-quarter were frustrated by the inability to use expensive drugs, because their patients could not afford the treatment, while one in six were frustrated by the hospital services which they saw as poor, and very often providing no report back to the general practitioner on patients referred to hospital.

During the interview we attempted to find out whether there was any way or ways in which the Medical School could in its training help to equip future general practitioners to deal with the type of frustrations mentioned. Only a third had some suggestions as to the type of things which could be attempted. The main suggestion was to have some form of apprenticeship during medical training whereby students could work for a period of time with a general practitioner. One of the main points made by those who felt the Medical School could not help with the frustrations they had described was that the real problem was the low socio-economic status of the Black

patients, and that education and training of these patients was required, and this was beyond the scope of the individual doctor.

Satisfactions derived from private practice were enquired into. The most frequently mentioned satisfaction was healing a patient, and being able to follow up progress. Equal numbers (amounting to a quarter in each case) liked being their own boss, and found that they obtained better financial remuneration than through hospital service. A similar proportion found it very satisfying getting to know their patients.

Our informants estimated that on average they saw a mean number of 40 patients a day. African doctors put the figure somewhat higher, with an average of 53 patients as against an average of 34 for the Indian doctors. In both cases the majority of the patients were African, but the Indian doctors had more Indian patients than did the African doctors. One-quarter of those in general practice reported undertaking some operations. The mean was low at an average of two per day. We have no way of knowing how accurate these estimates are. They point to very heavy case loads.

Anoterh problem sometimes mentioned by general practitioners, particularly those in isolated areas, is the difficulty of finding someone else with whom to discuss their day to day medical and professional problems. One in six of the graduates in private practice said there was no one with whom they could discuss these types of problems. Other doctors in the area, or hospital staff were the most usual source of colleagues for discussion, as only three of our general practitioners were in partnership. Almost two-fifths found the difficulty in contacting colleagues for medical discussions represented a problem. It seems that often the problem was not so much in finding a colleague to talk to, as in finding a more experienced colleague to give urgent advice.

Thirty per cent of those we spoke to said they experienced difficulty in referring patients to a specialist. In nearly all cases the reason was quite simply the inability of the patient to pay for consultation, and only two mentioned that White specialists refused to accept a Black patient. By far the greatest majority of patients were referred to a hospital for specialist services. Two-thirds of the doctors mentioned that either frequently or sometimes they experienced difficulty when referring a patient to hospital. The reasons were varied. Sometimes the problem was that the patients feared hospital and were unwilling to go. Other times the problem was that the doctors in the out-patient section of the hospital refused to admit the patient whom the general practitioner felt required hospital treatment. Another problem mentioned was that sometimes the hospital staff neglected to correspond with the general practitioner and let him know the treatment given to the patient in hospital.

All but three of the doctors we spoke to in private practice stated that they always sent a letter when referring a case to a specialist or hospital. The doctor's own findings, history of the treatment of the patient and the reason for referral were given in the letter. Most of the doctors reported that they attempt to follow-up patients sent to hospital, doing this either by telephone, or a personal visit or letter. Only five volunteered that the follow-up of patients in hospital was easy because of contacts they had with hospital staff. Six out of the 37 doctors in private practice said they had to rely on reports of patients themselves or relatives, as they were unable to get satisfactory information from the hospital.

17. DETAILS FOR THOSE IN HOSPITAL SERVICE.

Three-fifths of the 69 doctors we interviewed were in hospital service. Seven of them were in fact in part-time hospital service, and so had a private practice of their own. The positions within the hospital service covered the full range from medical officer up to medical superintendent. In fact the sample consists of one medical superintendent, two registrars, one senior consultant, two consultants, 11 senior medical officers and 24 medical officers. The average length of service was a mean of 4,6 years, and half those in hospital service had been there for three years or less. The longest length of service was 11 years. Only four regretted their decision to work in the hospital service, reporting that they were disgusted with the discriminatory pay, and found it difficult living on the hospital salary. The most frequently mentioned reason for entering hospital service was in order to gain further experience and to keep up-to-date with medical matters.

Questioned about frustrations and irritations, the doctors concerned reported a variety of factors. One-quarter said their major frustration was that the patient load was too heavy, so that it was difficult to give of one's best to each patient. A fifth were frustrated by being paid a differential salary according to race, while one in eight were irritated by administrative chores. A similar proportion were frustrated by having no say in the running of the hospital. Other factors mentioned amounted to a tenth or less of the cases, and included the "inefficiency" of the nursing staff, and the limited range of drugs which may be prescribed. (The range is limited by hospitals on economic grounds.)

Only four could suggest changes in the Medical School training which could possibly help future doctors entering the hospital service. The suggestions boil down to two suggestions - a suggested course in medical administration, and the recommendation that medical ethics deserves a more serious place in the curriculum than it has up until now.

The satisfactions which the doctors derived from their hospital service varied. Twenty-nine per cent were satisfied by the opportunity to keep up-to-date with medical knowledge and gain a wide clinical experience. A quarter mentioned the satisfaction of being able to follow up in-patients and watch their daily progress. One in six commented on the better equipment available in hospitals, which allows a "proper" clinical examination, and they also mentioned the access to consulting colleagues. Another one in six saw the hospital service as an opportunity to gain valuable training for later specialization, and this was a source of satisfaction. Mentioned by a similar proportion was the satisfaction derived from the availability of facilities which could be used for patients without problems of cost. Less frequently mentioned satisfactions were regular hours for work, and proper leave.

It is encouraging to note that only 15% of the doctors in hospital service found no satisfactions whatsoever in their jobs.

The patient load for those in hospital service was heavy. The doctors were asked to estimate the number of patients they saw daily. The average worked out to a mean of 48 patients a day, with three-fifths stating that they examined 50 or more patients daily. As far as operations were concerned the mean figure was 7,5 operations per day, with one in six having ten or more operations daily. Without knowing the nature of the operations one cannot judge just how heavy the load is, but it seems that the doctors were kept very busy.

Generally the doctors saw relations with their hospital superiors in the hospitals where they were working as good. Eighty-seven per cent saw their relations as good, with only 8% feeling that their relationships with superiors were bad. Ninety-five per cent saw their relations with colleagues of equal rank in the hospital as good, while in regard to relations with subordinates, comments were generally very favourable. In only 7% of the cases were problems with junior staff mentioned.

Turning to relations with non-medical staff, some problems do emerge. A quarter of the doctors see some problems in the relationship with the matron or matrons, while one in six felt that there was racial discrimination involved. Those who feel this way commented that White and non-White matrons tend to interfere in the doctor's work during his absence, while some felt that White matrons tend to disregard the non-White doctor's authority and in everyday working relations showed special favour to the White doctors. However only one in six mentioned this. Seventy-one per cent viewed their relationships with paramedical staff in the hospital as being good. Most of the remainder said they had in fact very little or no contact with paramedical staff and so could not comment. Only one commented that there was a racial

problem involved but did not elaborate.

Nearly all the doctors saw their relations with nursing staff in the hospital where they were working as satisfactory. However 22% qualified their remarks by stating that there were problems of inefficiency or irresponsibility at times on the part of the nurses. Only one doctor said there was a racial problem involved in his relations with the nurses.

Relations with administrative staff were not as good as with other types of hospital staff. Three-fifths saw relations as good to satisfactory, but one-fifth said that relations with administrative staff were fair or even bad with a tendency towards racial discrimination. Just under one-half felt that the administrative staff do not understand the problems doctors encounter. The majority also felt that whether they cared or not the administrative staff could do very little if at all to help doctors with their problems. This latter opinion is probably a realistic assessment by these doctors of the situation in which they find themselves.

18. DOCTORS' VIEWS OF THEIR PATIENTS.

Patients are the reason for the existence of doctors, and therefore a major part of the doctor's thought and time professionally revolves around the individual patient. During the course of our interviews we tried to obtain an idea of the characteristics of the "ideal" patient. Almost nine-tenths considered the ideal patient to be someone who is co-operative and patient, persisting with the treatment through to the end of the course. Providing an adequate case history with all relevant details was a characteristic mentioned by three-fifths of the doctors. Other characteristics were mentioned by far fewer doctors. One in six mentioned the patient should be satisfied with what the doctor tells him, while one in seven felt that the doctor should be left to decide how best to treat the patient. One in eight mentioned gratitude as a characteristic of the ideal patient, while one-tenth mentioned having confidence in scientific medicine, and not resorting to traditional medical practitioners (that is to herbalists and/or diviners).

The average patient had characteristics decidedly different from those which the doctors thought was ideal. Two-thirds of the doctors we spoke to said that their average patient came too late for treatment, while a third said that their patients did not carry out treatment as prescribed by the doctor. A fifth saw the average patient as being unable to give a clear and precise history of their complaint. Other characteristics were mentioned by a far smaller proportion of doctors. One in seven said that their average patient came when really ill, and therefore appreciated treatment, while one in eight thought that Africans were more appreciative than Indian patients, and that many of the

latter expected medicine to work like magic. A tenth thought that their average patient had difficulty in grasping the doctor's explanation of their illness, while a similar proportion put the complementary point of view that a lot of their patients still believe in traditional explanations of illness.

In order to obtain a clearer indication of what the doctors thought their average patient was like, we asked them to fill in with pencil and paper a likert-type test listing 19 polar characteristics of patients. Details are given in Appendix B. Table 7 provides mean scores for the various items, which are graphed in Figure 5. It will be seen that overall the Indian and African doctors had a very similar image of their patients, the one exception being that the African doctors saw their patients as being realistic and responsible, whereas Indian doctors saw the reverse. Generally the Indian doctors are more critical of their patients than were the African. Overall the general picture is that the doctors we spoke to saw their patients as being somewhat inactive, severely affected by problems, disorganized, rather lacking in ideals, and conservative. Conversely they saw them as important, (this was the most positive feature of the attitude profiles) good, true, and successful up to a point. They also saw them as kind, fair, and trustworthy. They do see their patients as being somewhat passive. In regard to whether or not the patients are clever or stupid, or competent or incompetent, the doctors expressed fairly neutral points of view on average.

The most frequent frustration which the doctors experienced when working with their patients was failure to follow a course of treatment. This was mentioned by two-fifths of the doctors, while a further quarter complained that their average patient was rather unco-operative, and gave an incomplete or inaccurate case history. One in eight mentioned the frustration of having patients coming in much too late for treatment, or refusing hospitalization and/or surgery. A tenth mentioned the frustration associated with patient flitting from doctor to doctor, while a similar proportion were frustrated by the ignorance and conservatism of the patients in regard to child-rearing. This made the treatment of kwashiorkor 'futile'.

Table 7.

Mean Scores Reflecting the Image Doctors have of "My Patients".

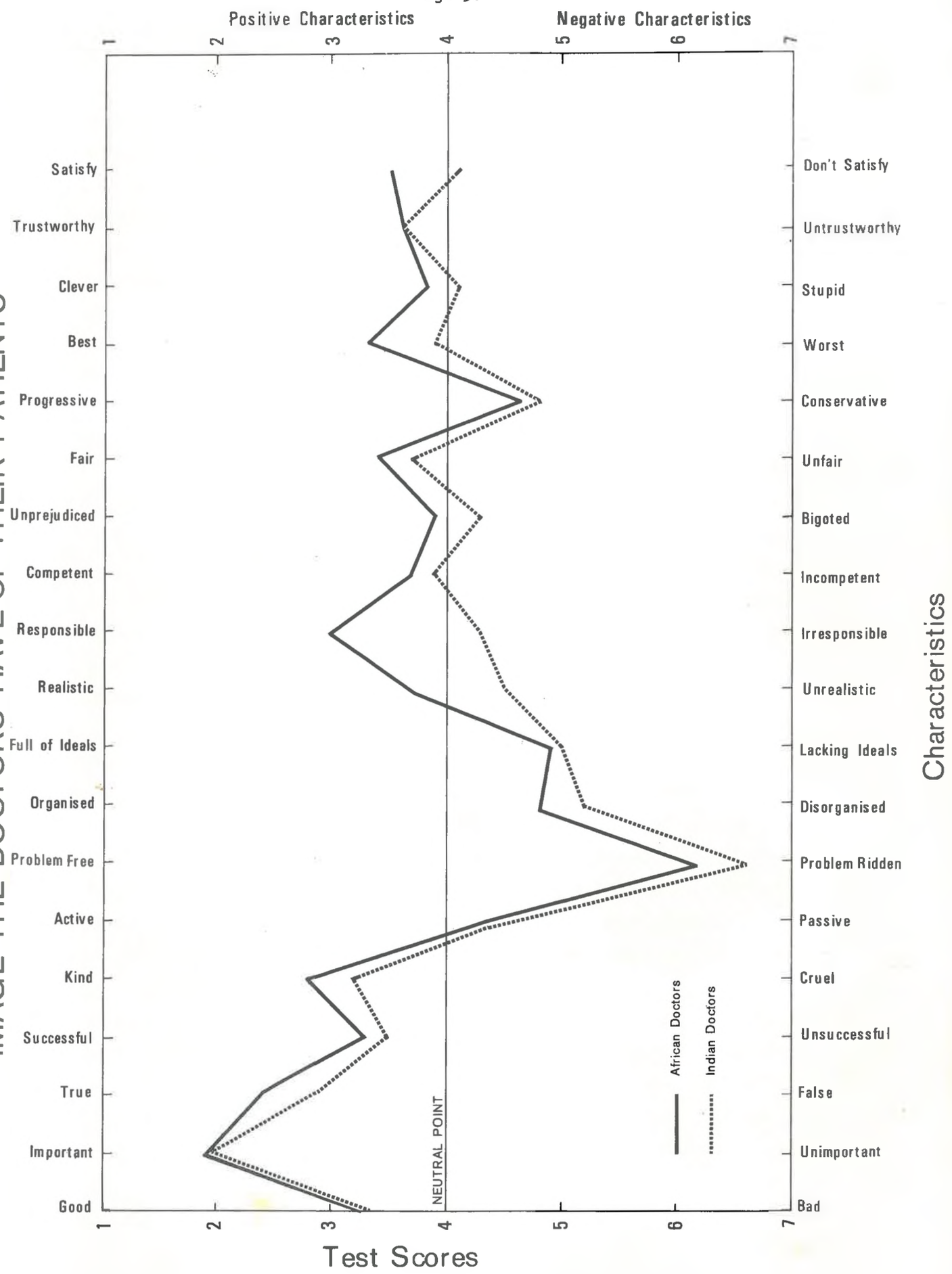
Polar Characteristic	Mean Scores		
	All cases $\bar{X}$	Africans $\bar{X}$	Indians $\bar{X}$
Good - Bad	3,3	3,3	3,3
Important - Unimportant	1,9	1,9	1,9
True - False	2,7	2,4	2,9
Successful - Unsuccessful	3,4	3,3	3,5
Kind - Cruel	3,0	2,8	3,2
Active - Passive	4,3	4,3	4,4
Problem-free - Problem-ridden	6,4	6,2	6,6
Organized - Disorganized	5,0	4,8	5,2
Full of Ideals - Lacking Ideals	5,0	4,9	5,0
Realistic - Unrealistic	4,1	3,7	4,5
Responsible - Irresponsible	3,7	3,0	4,3
Competent - Incompetent	3,8	3,7	3,9
Unprejudiced - Bigoted	4,1	3,9	4,3
Fair - Unfair	3,6	3,4	3,7
Progressive - Conservative	4,7	4,6	4,8
Best - Worst	3,6	3,3	3,9
Clever - Stupid	1,2	3,8	4,1
Trustworthy - Untrustworthy	3,6	3,6	3,6
Satisfy - Do not satisfy	3,8	3,5	4,1
All Items	3,7	3,7	4,1

19. RESPONSIBILITIES OF A DOCTOR TOWARDS HIS PATIENT.

How do doctors conceive of their responsibilities towards their patients? Over four-fifths said the responsibility was to provide the best treatment and advice, after the correct diagnosis of the ailment. A third felt that the responsibilities included explaining the patient's illness to him/her, and the course of treatment to be followed. A quarter mentioned reassuring and comforting the patient when necessary as an important responsibility.

FIG. 5.

IMAGE THE DOCTORS HAVE OF THEIR PATIENTS



A fifth mentioned the responsibility of helping the patient to solve all problems arising from his/her illness. Other responsibilities mentioned by a sixth or less of the cases were following up the patients systematically until they were cured; consulting colleagues or referring the patient when necessary; being honest with the patient; maintaining a good relationship with patients so that they feel free to approach them at any time, and keeping all information about patients strictly confidential.

The interviews probed to what extent the doctors felt that in practice they could fulfil these ideal responsibilities. Only a quarter of the doctors felt that it was possible to fulfil most of these ideal responsibilities. Reasons for not being able to fulfil these responsibilities were the heavy patient load carried by the doctor, the inability of patients to afford the expense of drugs or specialist treatment, and the failure of patients to carry through with the treatment.

Obviously an important aspect of a doctor's responsibilities towards patients is to obtain accurate information necessary for effective treatment. Three-fifths of the doctors saw some socio-economic history of the patient as being an important part of the necessary information. One in six mentioned the necessity of knowing something about the patient's beliefs about illness and attitude towards scientific medicine. These were seen as additional items to the basic one of obtaining a sufficiently detailed case history. The comments of the doctors are a reflection of their experience.

20. DIFFICULTIES EXPERIENCED IN KEEPING ABREAST OF MEDICAL KNOWLEDGE.

Given the rate of development in medical knowledge it can be a serious problem for the hard-pressed doctor to keep abreast of medical knowledge. We were interested in finding out to what extent the graduates of the Medical School found this a problem. A third of them admitted that pressure of work left them with little or no time for reading, or attending discussions and meetings. A further one in ten said that they had insufficient time for reading, and had problems in maintaining adequate contact with colleagues. Other comments varied, but in one way or another they all admitted that there was a problem in finding time for reading journals, and said that sometimes they felt cut off from their colleagues or meetings that were organized for their benefit. In fact only one in seven admitted that they had ample opportunity for reading and discussion - and interestingly enough these were medical officers at the large Durban hospital, King Edward VIII Hospital.

Two-thirds of the doctors we spoke to subscribed to one or more journals, and just under half borrowed journals regularly. The two main journals subscribed to were either the South African Medical Journal and/or

the British Medical Journal.

Half of the graduates felt that the South African Medical Association helped one to keep abreast. The main ways in which they said this happened was by means of sending out literature, arranging meetings, seminars and discussions.

We asked the doctors to estimate how much time they spent a month on study. Admittedly it is difficult, particularly for a busy man, to make an accurate estimate unless he has kept a diary. However for what it is worth, the mean figure quoted was an average of 39 hours spent on reading, or about one hour twenty minutes daily. Half said they spent less than 36 hours a month on studying journals and other literature. The Indians quoted a much higher mean figure, 43 hours monthly, as against 31 hours by the Africans. None of the Indians in our sample said they had no time to study, whereas 16% of the Africans reported that they were unable to study.

21. BEHAVIOUR OF MEDICAL PRACTITIONERS.

Doctors are much in the public eye, and are thus expected both by the public and by colleagues to conform to certain patterns of behaviour. Half of the doctors found certain aspects of the public expectations of them frustrating or even distasteful. Three main themes emerged. The one was being put on a pedestal, and expected to have unrealistically high standards of behaviour. As human beings with failings like anyone else, some doctors disliked this. Many of them disliked very much the expectation that they must be available at any time of the day or night, and must make unnecessary house calls whenever a patient deemed fit to call on them. The third source of public behaviour which was disliked was the expectation on the part of others that they should give free medical advice to friends, relatives and even sometimes patients who saw the doctor as being very rich.

During the preliminary stages of our fieldwork, we came across opinions expressed by some informants, both inside and outside the medical profession, that the incidence of alcoholic abuse and drug abuse by Black doctors is high enough to represent a problem. We endeavoured to obtain some indication of how the Black doctors themselves saw this situation. One-third felt that there was a tendency for some doctors to drink too much, and saw this as leading to the risk of alcoholism. Those who did see a higher incidence of drinking occurring than amongst the general population referred to the tensions and frustrations generated by medical practice - one faced the ills of mankind, which were often aggravated by poverty, and ignorance. One in six of the informants thought that Black doctors, particularly Africans, had additional sources of frustration which their White counterparts did not

experience. Laws curbed their freedom, and they faced far more limited outlets for recreation and relaxation in non-White communities than was the case with their White colleagues. However a frequently recurring theme - the most frequently mentioned one in fact - was the strain and stress of being a doctor, and therefore always facing the grim side of life - illness, poverty, ignorance, and death. A few of the informants mentioned that the doctors were a middle-class, cut off from the ordinary folk, and somewhat isolated by their higher status in communities which had very few professional or other middle-class people with whom the doctors could interact.

Most of our informants felt that there was very little if any drug abuse amongst doctors. Only seven of the doctors we spoke to felt that there was a sufficient incidence of drug abuse to represent a problem. The reasons given for this were very similar to those given for consumption of excessive amounts of alcohol. The only additional reason given is the obvious one that doctors are exposed to the temptation of easy access to drugs, in the way that non-medical men are not.

Sexual promiscuity and/or extramarital sex were seen by a fifth of the doctors as occurring to a significant extent amongst their colleagues. They thought this occurred because of the open admiration of doctors by a lot of women, and also because of the relatively high income which Black doctors enjoy with few outlets in their community for spending money and/or also because of the strains and stresses of the job which lead to a need to find escape.

22. ATTITUDES TOWARDS MEDICINE AS A CAREER.

Probably the most searching question one could ask an individual about his career is whether given his life over again, he would again make the same choice. Put another way, one can ask whether one would recommend in this case medicine as a career to an intelligent and ambitious person. As far as young men were concerned, 80% of the male African doctors, and 75% of the Indian male doctors said that they would definitely recommend medicine as a career for a young man. The two main reasons given for this were the need for more doctors, and secondly that a career in medicine paid reasonably well. The number of women doctors in the sample was small. Half of the Indian women doctors and three-fifths of the Africans said that they would recommend medicine as a career for an intelligent and ambitious young woman. The reasons tended to be rather different from those of men. The most commonly mentioned reason was that there was little else for intelligent non-White women to do, and a small proportion mentioned that women patients preferred to be examined by women doctors. The main reason given by those who felt that they could not

recommend medicine to young women was the difficulty female doctors had in coping with married life and doctoring.

Three-fifths of the doctors we spoke to said if they had a completely free choice and could start their life again, they would choose medicine a second time. Twenty per cent were unsure, and the remaining one in six were quite clear that they sould not choose medicine again. Those who said they would choose medicine again saw it as the best profession available, and very gratifying and fulfilling. The main reason given by those who would not choose it again was that it was too strenuous and involved far too much overtime work. Being asked whether they would choose exactly the same branch of medicine again, just under half said they would. The typical reason given by those who would not choose the same branch of medicine again was that they would like to specialize. In fact being questioned about future plans, the largest single number (about a third) wanted to specialize in future, while a quarter wanted to move into general practice.

23. ATTITUDES TOWARDS, AND EXPERIENCE OF, FOLK MEDICINE.

Important sectors of the African and Indian population are still traditionally oriented, and this means that they subscribe to a greater or lesser extent to traditional explanations of illness and health, and also turn to traditional sources of treatment for illness. This is a reality which all Black medical doctors have to face. Consequently we questioned them on their attitudes towards and experience of folk medicine. About half of the doctors felt that there were some aspects of folk medicine which are of practical value. Practices relating to cleanliness and quarantine of infectious diseases were seen as important, while some of the doctors felt that certain herbal remedies were either harmless or actually beneficial. The major constructive role of traditional viewpoints seemed to be the psychological supports which they provided for the patients. On the other hand, some doctors pointed out that the traditional remedies used were often very toxic, and enemas dehydrated the patients. The beliefs and practices were of course unscientific, and some doctors felt that this made it difficult to gain the whole-hearted co-operation of a patient who believes in these practices. A serious consequence of folk medicine was that patients very often made their first attempt at cure through traditional means, and this delayed patients in coming for scientific medical treatment.

Just under three-tenths of the African doctors and two-fifths of the Indians felt that to a greater or lesser extent some folk medicine practices can be integrated into the practice of scientific medicine.

Three-quarters of the Indian doctors and a third of the African doctors we spoke to felt quite definite that in some cases traditional and scientific medicine should be used side by side. The crucial point is in what way this should be done. Where traditional approaches interfered with treatment, and retarded the education of the patient, then the doctors felt that the two different approaches could not be used together. However a quarter pointed out that traditional approaches give a psychological sense of security to the patient, and this sense of security should not be lightly disturbed unless it was absolutely essential. To give one specific case in point, one should not, as happened in a case that was reported to us, cut off the fur armlet of an African patient when the patient was admitted to hospital, doing it with the comment that "one cannot have such nonsense here". This upsets the patient and removes a source of security, which if left would in no way have hampered the treatment. Ritualistic practices were seen by some doctors as needing neither encouragement or discouragement. Some of the doctors were explicitly pragmatic. They said it was impossible to uproot traditional practices, and that where the patient's health was not jeopardised by them it was wise to quietly condone such practices and beliefs. A very important point which was made by one-tenth of the doctors was that during their training medical practitioners should be taught about traditional beliefs and practices of both African and Indian patients, so that when they started practice they would have insight into a situation in which many of their patients found themselves.

Questioned about whether or not they had actually seen a case where folk medicine had helped a patient, the major reply of those who said that they had had such an experience was that *Inyangas* can help with psychosomatic illnesses, particularly with asthma and hysteria.

A not unusual experience of the Black doctor is to be faced with the problem of allaying the anxiety of a patient who sees his or her illness in terms of traditional folk explanations. Different approaches were advised by different doctors, and clearly they related to different types of cases. Some said one should tranquilize the anxious patient and then treat the physical symptoms only. Others said one must be very firm and scold the patient about his or her wrong beliefs. As social scientists we feel that this particular approach is very wrong, and the medical training of students should make it quite clear that whether or not they agree with the patient's worldview and explanations, these must not be brushed aside or made a source of guilt. A more effective approach was the one which advocated that the doctor attempts to explain illnesses in simple western terms, but at the same time does not reject outright or belittle the traditional views. One in eight of the doctors were apparently so inflexibly "scientific" in their approach

to medicine that they show no sympathy whatsoever for the worldview of patients who may be traditionally oriented. All but one of these doctors were Indian. The rest in various ways showed an awareness of the patient's definition of the situation, and tried to deal with it sympathetically and wisely without derision or scolding. By and large this was very encouraging, but it is nonetheless a cause for concern that not all the doctors were able to share this approach.

Some of the patients of Black doctors demand an injection, believing that it is the appropriate form of treatment. There were two main ways the doctors said they handled this type of patient. Only 7% said that they never ever gave an injection that was not required by the physical state of the patient. The rest said that where the patient very strongly wanted an injection and seemed to believe that a treatment would not work without it, they gave the appropriate treatment, and if this did not include an injection, then they gave a vitamin injection in addition to the treatment.

Another aspect of folk medicine is that some of the patients, typically African patients, come to the doctor expecting him to behave like a diviner telling them their complaints without asking any questions. Four-fifths of the doctors said that they had experienced this type of problem during the course of their practice. They said it was mainly found amongst rural Africans and the older patients, and particularly amongst the illiterate. Questioned on how they would handle this type of patient, only two said that they would refuse to treat patients who would not talk. All the others said they would strive to get the patients to talk, and either by indirect questioning and/or commenting on the results of a physical examination and observation, would make comments that would encourage the patient to talk and agree or disagree with statements.

Some of the doctors were quite sure that the patients they had were not only consulting them but at the same time consulting a traditional diviner. Most of the doctors (three-fifths) said they would not be particularly worried if they knew that this was occurring. The theme underlying most of the reasons given for this was that provided consulting a diviner does not interfere with a doctor's treatment, and provided that the patient does not take a harmful substance, the patient's psychological needs are met by the traditional practitioner, while the scientific practitioner gets on with the job of actually curing the patient.

24. THE INCIDENCE OF MALNUTRITION AND PELLAGRA.

Malnutrition is the health problem which every Black medical doctor finds, and our sample estimated the proportion of their patients who were malnourished. The mean estimate of the proportion of patients estimated to suffer from malnutrition was two-fifths. Half the doctors saw the handling of malnutrition as involving not merely treatment but trying to educate the patients - and very often this meant the parents of a child - about the causes of malnutrition, and trying to tell them about the best cheap diets available. One-fifth of the doctors felt that the training they had received in regard to malnutrition was inadequate. The main reason for this seemed to be the view that preventative medicine had been very skimpily handled during their training, and that as students they should have been given far more practical experience in the townships.

The average estimate for the proportion of patients encountered who suffered from pellagra was a figure of one-fifth. However the estimates varied very widely from over half to under 10% of the patients.

CONCLUDING REMARKS.

A sample of graduates from the Medical School of the University of Natal was interviewed at length. A total of 69 doctors were interviewed on average for 3 hours or longer about their views on their training, and their subsequent medical careers. Difficulties in securing response led to a higher than usual non-response rate, but nonetheless the results are deemed worth considering. Likert-type attitudinal scales and incomplete sentences were used during the interviews. A further 11 doctors replied to a postal questionnaire sent to those who could not be reached for an interview.

The findings present a picture of not only individual variation but also of attitudes and experiences which form patterns common to groups of doctors. As it is the detail which is of interest to medical administrators and academics no attempt is made here to summarise the results. Areas for additional teaching are evident, and these include social and preventive medicine, a description and analysis of traditional folk medicine and belief systems, and the handling of a general practice, and hospital administration. As far as is known, the particular form this investigation has taken is unique in South Africa, and in the literature generally. Consequently we have no way of knowing to what extent our findings are typical of South African Medical Practitioners generally, or typical even of doctors in the Western world. It is postulated that many of the findings will apply widely in South Africa, particularly to doctors whose practice is not restricted to

only the wealthy and pampered amongst the Whites. However, further research is needed to confirm or refute this suggestion.

In December 1975 it was announced that the Cabinet of the Republic of South Africa had decided that within a few years' time all African medical students must go to a medical school being created by the University of South Africa in a peri-urban African area in the Pretoria region - in Ga Rankuwa, It is highly likely that in the near future Indians will have to go to the Indian University of Durban-Westville (which wants, but at present does not have, a medical school). Likewise Coloureds will probably go to a proposed medical school at the (Coloured) University of the Western Cape at Belville. This means in effect that the Medical School of the University of Natal as a Black medical school will be dismantled by Cabinet decision, and our findings relate to what may be a dying institution. This was a possibility foreseen (but certainly not hoped for) when the research was originally planned. After all, the University of Natal as a "White" University had a "Black" Medical School, and this did not fit in tidily with the logic of separate development. It was considered that our findings will be useful to any academic institution in South Africa responsible for training Black medical practitioners, and so the research programme went ahead. It is hoped that the findings will be studied by all concerned with the education of Black doctors.

APPENDIX A.

DETAILS OF THE SAMPLE OF GRADUATES OBTAINED FOR THE STUDY

APPENDIX A.

DETAILS OF THE SAMPLE OF MEDICAL GRADUATES DRAWN FOR THE STUDY, NOVEMBER 1970

Working from graduant lists and the Medical register for 1970, the following details were obtained for the total of 126 African, 154 Indian and 18 Coloured graduates of the Medical School of the University of Natal. The details of the sample drawn are also shown:

TABLE A.1

REGION PRACTISING IN AS AT 1970	RACE OF GRADUATES			
	AFRICANS		INDIANS	
	Universe	Sample	Universe	Sample
Durban-Pietermaritzburg and surrounding districts	24	14	121	41
Johannesburg-Pretoria and surrounding districts	24	13	12	3
Transkei and Pondoland	19	11	-	-
Rest of South Africa	20	12	16	6
TOTAL FOR REPUBLIC OF SOUTH AFRICA	87	50	149	50
Rhodesia	8		-	
The rest of Southern Africa outside the Republic of South Africa	8		1	
Central Africa	6		-	
Rest of world	10		4	
Deceased	7		-	
TOTAL	126		154	

NOTE: In addition there were 18 Coloured graduates, of whom 17 were living in South Africa in 1970. They were not sampled, as they formed such a small group of the graduates. Only Indians and Africans were studied.

A stratified sample of 50 African and 50 Indian doctors within South Africa was drawn. No Coloureds were drawn as they represented only 6% of the 236 registered graduates in South Africa. Fieldwork interviewing was attempted in the Durban-Pietermaritzburg, Johannesburg-Pretoria, and the Transkei areas. Other areas in South Africa were too far away from Durban to make

interviewing of a handful of cases economical. Consequently a questionnaire (shown in Appendix B) was posted to the total of 18 sample cases in these areas. This questionnaire represents a shortened form of the interview schedule.

In addition to the 100 cases from South Africa, Rhodesia was visited, and interviews were conducted in order to obtain some idea of graduates from outside South Africa. Twenty-two Africans, and one Indian doctor were living in Central and Southern Africa, outside of the Republic of South Africa. Of these, 8 were in Rhodesia.

An attempt was made to interview cases in England and Scandanavia, again in order to obtain data on doctors who were outside South Africa. Twelve were in England and one in Norway. Dr. Eleanor Preston-Whyte of the Department of African Studies at the University of Natal, while on sabbatical leave in Europe, interviewed as many cases as was possible. Finally, the postal questionnaire was also sent to cases outside South Africa who could not possibly be interviewed.

TABLE A.2.

FIELDWORK RETURNS FOR NUMBER OF COMPLETED INTERVIEW SCHEDULES AND POSTAL QUESTIONNAIRES 1971.

REGION	Number of Completed Interviews		
	Africans	Indians	Coloureds
Durban-Pietermaritzburg and surrounding areas	8	28	1
Johannesburg-Pretoria and surrounding areas	8	1	-
Eastern Cape and Transkei	2	1	-
Rest of South Africa	4	6	-
Rhodesia	5	-	-
England	5	-	-
TOTAL	32	36	1
REGION	Number of Completed Postal Questionnaires		
South Africa	4	2	-
Rest of Africa	-	1	-
England	-	2	-
United States of America	-	2	-
TOTAL	4	7	-
GRAND TOTAL	36	43	1

NOTES:

1. Coloureds were not sampled. However, one "Indian" turned out to be a Coloured. (Race had been determined by surnames).
2. The questionnaire was posted to those in the sample from the Republic who were too remote to be interviewed; and to all cases outside South Africa who were not interviewed. It was sent to 12 Africans in South Africa, and to 31 Africans and 5 Indians outside of South Africa.

Table A.2 shows the response obtained. Overall, interviews or postal questionnaires were obtained from 26 Africans or 52% of those in South

Africa. The corresponding response for Indians was 38 or 76%. The response rate for interviews only, in South Africa, was 58% for Africans. One of the reasons for the low return was that a fieldworker in the Transkei failed to produce any schedules, and all attempts to obtain them failed. It was not possible, due to cost and the time factor, to later send another worker into that area. The response rate for Indians interviewed in South Africa was 82%. Most of them lived in or near Durban, and it was possible to supervise fieldwork closely, with a consequently much better response rate.

The fieldwork was difficult. Interviews with doctors proved difficult to arrange, both because of the little free time available to most doctors, and also because the interviews were long - at least three hours each. (Detailed interviews were required, and it was decided not to shorten the length of the interviews). Often an interview had to be spread over several meetings, and consequently the fieldwork was spread over the latter part of 1970 (when the pilot survey was undertaken), and 1971. A variety of African and Indian interviewers were used, under the direction of a White Social Science graduate. In three cases, (one was African) a complete refusal to be interviewed was met with.

The sample must have some biases, due to the unsatisfactorily high level of non-response, consequently confidence limits and tests of significance have not been used. However, there is no evidence of any systematic biases. The results are analysed as referring to the sample, with no attempt to state what the position of all graduates is. Nonetheless, the variation in replies is often small enough to make one fairly confident that the results do provide some idea of all graduates turned out by the Medical School.

The fieldwork was carried out at a time when there was considerable overt resentment on the part of Black doctors about racial discrimination in the then new salary scales for doctors in the hospital services. (Whites had the highest salaries, Africans the lowest with Indian and Coloured doctors in between, and the differences had increased). We were concerned about the possible effects of this on fieldwork, but there is no evidence to suggest the non-response rate was increased thereby.

APPENDIX B.

THE FIELDWORKERS' MANUAL, INTERVIEW
SCHEDULE, SENTENCE COMPLETION AND
LIKERT-TYPE TESTS, AND
POSTAL QUESTIONNAIRE USED FOR THE FIELDWORK.

INSTITUTE FOR SOCIAL RESEARCH
University of Natal,
Durban.

STUDY OF THE GRADUATES OF THE MEDICAL SCHOOL OF THE UNIVERSITY OF NATAL.

Fieldworkers' Manual

I.1. General Instructions.

You will be given a list of doctors whom you are to interview. When contacting a doctor and requesting co-operation for the survey, use the 'Introductory Patter' provided below: it is important that you make it clear that:

(a) you are working for the University of Natal.

(b) the survey is strictly confidential.

(c) the value of the research will depend on full co-operation from all the doctors drawn in the sample.

Introductory Patter

Since the 1950's there has been considerable interest in medical education. Medical Schools have appraised their training, and investigated what happens to their graduates. Studies done in the United Kingdom and America have tended to concentrate on students with little work on graduates. The University of Natal has followed these investigations with interest. Now that over a decade has passed since its first batch of students graduated, it is worthwhile for such a study to be undertaken. So it is that the Institute for Social Research is undertaking what is the first study in South Africa along these lines. Funds for the investigation have been provided by the Human Sciences Research Council.

The study is divided into 3 main phases:-

The present students (who have already been studied by the Institute);

The graduates (whom we are currently studying by means of a sample); and

The general public image and expectations of the doctor.

We need your particular co-operation in the second phase of the study concerning graduates. We want to know what you think of your training in retrospect, and how you have been able to utilise it, and whether it prepared you for the problems of medical work and position as a professional man. We would very much appreciate any comments or criticisms you can make from your personal experience. All the information is confidential and we would stress that it will be impossible in the final report for anyone to identify a particular informant. You will appreciate that research is only as good as the information obtained, and so we need your full and continued co-operation, as well as that of all the other graduates drawn in our random sample.

While there cannot be any immediate benefits arising out of this research,

12. If the doctor shows signs of being worried during the interview, try to find out why, and attempt to re-assure him/her. You will find watching the eyes will assist you to spot tension or suspicion.

13. If need be because of time, spread an interview over two or three visits. However if you know the interview really well so that it flows as a conversation without long lapses, you may well be able to complete the interview in one long session.

14. Try to know your schedule well enough so that while you are writing down an answer to a previous question, you are at the same time asking the next question, and giving the subject a chance to think while you finish writing.

15. Once you have completed an interview, before taking your leave of the doctor, check through the schedule to make sure you have omitted nothing. It is far easier to fill in any gaps while you are still with the doctor, than have to go back later for a re-visit.

16. Take any problems that you encounter in the field situation to your fieldwork supervisor, and discuss them fully with her. When in doubt do not guess what to do, but check with your supervisor.

II. Instructions Regarding Specific Questions.

In addition to the above general instructions, the following points should be noted in regard to specific questions in the interview schedule. For ease of reference the item number identifying the part of the question concerned is referred to.

1. Page 1. - Record of Arrangements for Interview:
Please be careful to fill in all the contacts you have made with a particular doctor, whether by letter, telephone or personal visit. The outcome of each contact must be noted. Where non-response has been obtained you must carefully note the reasons for the final non-response - that is where the interview was not possible and has been written off as failure.

2. Page 2: This page is not to be filled in by the interviewer. It is to be completed by the office.

3. Item 7: 'Urban' refers to a town or city, whereas 'Rural' refers to everything else. Where a practice is 'Rural and Urban' the doctor has both a town and country practice and treats patients in both areas. This in fact implies that he is willing to go into the rural areas. Where he stays in town and has country patients coming to him, classify it as an 'urban' practice.

4. Item 9: In instances such as this throughout the schedule the individual blocks containing different answers have both the item and the code. Thus the category 15-19 implies the ages 15-19 the subject first decided to become a doctor, and the code is number 3. It is the code 3 which you fill in at the right hand side of the page in the empty block, having first placed a bold cross over 15-19.

5. 'Open ended' questions such as those for Items 10-11 require you to probe where you judge an inadequate answer has been given. Be particularly careful about probing in instances such as for Item 14 where reference is made in the questionnaire to the need to probe. This does not mean that

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INSTITUTE FOR SOCIAL RESEARCH

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Schedule No. [ ]

GRADUATES OF THE MEDICAL SCHOOL OF
THE UNIVERSITY OF NATAL

MAIN FIELDWORK, 1970.

NAME: .....

ADDRESS: .....

.....

.....

.....

DATE OF INTERVIEW: .....

INTERVIEWER: .....

Record of Arrangements for Interview			
Date of Contacts	Method of Contact	Outcome	Fieldworker

REASONS FOR FINAL NON-RESPONSE (IF ANY): _____

_____

_____

_____

SCHEDULE CHECKED BY: .....

DATE: .....

Nature of Current Practice:

6.

Intern	Hosp. Serv.	G.P.	Spec.in pvt prac.	Teach.	Further Study	Given up med.	Retired
1	2	3	4	5	6	7	8

Area Practising In:

7.

Urban	Rural	Rural and Urban	N.A.
1	2	3	4

Name of Area where subject practises:

8.

Town: _____

District: _____

At what age did you first decide to become a doctor?

9.

<10	10-14	15-19	20-24	25-29	30-34	35-39	40+
1	2	3	4	5	6	7	8

What made you decide to take up medicine?

10. _____

_____

_____

11. _____

_____

LOOKING BACK ON YOUR MEDICAL TRAINING AT THE UNIVERSITY OF NATAL, WHAT DO YOU THINK OF IT?

12. _____

_____

_____

_____

13. _____

_____

_____

_____

Teaching Methods:_____

21. _____ ☐
_____
_____

Qualities of Staff:_____

22. _____ ☐
_____
_____

Work Load:_____

23. _____ ☐
_____
_____

Relations with Teaching Staff:_____

24. _____ ☐
_____
_____

Relations with Administrative Staff:_____

25. _____ ☐
_____
_____

Relations with Fellow Students:_____

26. _____ ☐
_____
_____

Residence:_____

27. _____ ☐
_____
_____

Bursaries/Financial Assistance:_____

28. _____ ☐
_____
_____

Most students encounter some problems during their stay at university. Looking back on your medical student days at the University of Natal what <u>personal problems</u>, other than financial, did you experience?

38. ---

Did you approach any member of staff for assistance with these problems?

YES	N.A.	NO
1	2	

If not, why not?

39. ---

If yes, what form did the help take?

40. ---

If you did approach staff, what quality of help did you receive?

41.

Effective help	1
Ineffective help - staff could have helped more	2
Ineffective help - staff could not have been expected to help more effectively than they did	3
No help, despite seeking it from staff	4
Did not seek staff help	5
Had no personal problems	6

What do you suggest should be done today to help students with financial problems?

47. ---

What academic problems did you encounter as a medical student at the University of Natal?

48. ---

Did you approach any member of staff for assistance?

YES	N.A.	NO
1	2	

If not, why not? ---

49. ---

If yes, what form did the help take? ---

50. ---

If you did approach staff, what quality of help did you receive?

51.

Effective help	1
Ineffective help - staff could have helped more	2
Ineffective help - staff could not have been expected to help more effectively than they did	3
No help, despite seeking it from staff	4
Did not seek staff help	5
Had no academic problems	6

The nursing staff? _____

58. _____ ☐

_____

_____

From your experience, how many years should mandatory internship cover?

1 yr.	2 yrs.	D.K.
1	2	3

59. ☐

How do you think the time and content of the internship period should be arranged? _____

_____

_____

60. _____ ☐

_____

_____

PLEASE DESCRIBE IN SOME DETAIL THE TYPES OF PROBLEMS WHICH YOU FEEL A DOCTOR IN YOUR POSITION TYPICALLY HAS TO CONTEND WITH:

a) As an intern? _____

_____

61. _____ ☐

_____

62. _____ ☐

_____

b) In hospital service as a Medical Officer (or higher grade)? _____

_____

63. _____ ☐

_____

64. _____ ☐

_____

c) In private practice? _____

_____

65. _____ ☐

_____

66. _____ ☐

_____

DETAILS OF HIS/HER CAREER SINCE GRADUATING WITH MB.B.Ch. FROM THE UNIVERSITY OF NATAL UP TO THE PRESENT:

(include post graduate studies and non-medical full-time jobs held since qualifying as a doctor).

	Dates	No.of years	Job Description title/and rank	Institution/ Employer	Town/ District	Reasons for Activity/Change involved (where training influenced decision, indicate this)	Problems Encountered at this Stage of Career (include professional and other problems associated with your career)
1							
2							
3							
4							
5							

NOTE: If respondent has stopped practising medicine, give reasons.

LIST THE NUMBER OF MEDICAL MEETINGS OF THE FOLLOWING TYPES YOU HAVE ATTENDED: (Indicate capacity in which you attended):

80. i) Overseas Conferences: No._____

Capacity attended:

	Organising Committee Member	Author	Official Delegate	Individual Member/ Observer	N.A.
81.	1	2	3	4	5

82. ii) South African Conferences: No. _____

Capacity attended:

	Organising Committee Member	Author	Official Delegate	Individual Member/ Observer	N.A.
83.	1	2	3	4	5

84. iii) Regional/Local Meetings of the Medical Association: No._____

Capacity attended:

	Organising Committee Member	Author	Official Delegate	Individual Member/ Observer	N.A.
85.	1	2	3	4	5

No. of professional (medical) publications you have to your credit as author or co-author:

86. Journal articles:_____

87. Books: _____

Awards, honours you have received:_____

_____

88. _____

_____

_____

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INSTITUTE FOR SOCIAL RESEARCH

STRICTLY CONFIDENTIAL

Schedule No. [ ]

GRADUATES OF THE MEDICAL SCHOOL OF THE UNIVERSITY OF NATAL

MAIN FIELDWORK, 1970.

NAME: .....

ADDRESS: .....

.....

.....

.....

DATE OF INTERVIEW: .....

INTERVIEWER: .....

Record of Arrangements for Interview			
Date of Contacts	Method of Contact	Outcome	Fieldworker

REASONS FOR FINAL NON-RESPONSE (IF ANY): _____

_____

_____

_____

SCHEDULE CHECKED BY: .....

DATE: .....

THIS PAGE FOR OFFICE USE ONLY.

Item No.	Question	Code
1.	Schedule No.	
2.	Raising Factor	

3. Year Subject entered Medical School

1951	01	1955	05	1959	09	1963	13
1952	02	1956	06	1960	10	1964	14
1953	03	1957	07	1961	11		
1954	04	1958	08	1962	12		

4. Year Completed Medical School Training

1955	01	1959	05	1963	09	1967	13
1956	02	1960	06	1964	10	1968	14
1957	03	1961	07	1965	11	1969	15
1958	04	1962	08	1966	12		

5. Graduated:

On Schedule	1
One year extra	2
Two years extra	3
Three years extra	4

Nature of Current Practice:

6.

Intern	Hosp. Serv.	G.P.	Spec.in pvt prac.	Teach.	Further Study	Given up med.	Retired
1	2	3	4	5	6	7	8

Area Practising In:

7.

Urban	Rural	Rural and Urban	N.A.
1	2	3	4

Name of Area where subject practises:

8. Town: _____

District: _____

At what age did you first decide to become a doctor?

9.

<10	10-14	15-19	20-24	25-29	30-34	35-39	40+
1	2	3	4	5	6	7	8

What made you decide to take up medicine?

10. _____

_____

11. _____

_____

_____

LOOKING BACK ON YOUR MEDICAL TRAINING AT THE UNIVERSITY OF NATAL, WHAT DO YOU THINK OF IT?

12. _____

_____

_____

_____

13. _____

_____

_____

_____

AFTER GENERAL COMMENTS HAVE BEEN MADE BY RESPONDENT, PROBE IN THE FOLLOWING AREAS OF THE TRAINING, INCLUDING PROBES FOR CHANGES WHICH HE/SHE FEELS SHOULD BE MADE:

Theory: _____

14. _____ ☐
_____
_____

Practical Lab. Work: _____

15. _____ ☐
_____
_____

Clinical Work: _____

16. _____ ☐
_____
_____

Balance between Theory/Lab. Work/Clinical Work: _____

17. _____ ☐
_____
_____

Course Sequence: _____

18. _____ ☐
_____
_____

Content of Courses: _____

19. _____ ☐
_____
_____

Examination System: _____

20. _____ ☐
_____
_____

Most students encounter some problems during their stay at university. Looking back on your medical student days at the University of Natal what personal problems, other than financial, did you experience?

38. _____ ☐

_____

_____

_____

_____

Did you approach any member of staff for assistance with these problems?

YES 1	N.A. 2	NO

If not, why not? _____ ☐

39. _____

_____

_____

If yes, what form did the help take? _____

40. _____ ☐

_____

_____

If you did approach staff, what quality of help did you receive?

41. ☐

Effective help	1
Ineffective help - staff could have helped more	2
Ineffective help - staff could not have been expected to help more effectively than they did	3
No help, despite seeking it from staff	4
Did not seek staff help	5
Had no personal problems	6

What do you suggest should be done today to help students with personal problems?

42. _____ _____ _____ _____ ☐

What financial problems did you encounter as a medical student at the University of Natal?

43. _____ _____ _____ _____ ☐

Did you approach any member of staff for assistance?

YES	N.A.	NO
1	2	

If not, why not? _____

44. _____ _____ _____ ☐

If yes, what form did the help take? _____

45. _____ _____ _____ ☐

If you did approach staff, what quality of help did you receive?

Effective help	1
Ineffective help - staff could have helped more	2
Ineffective help - staff could not have been expected to help more effectively than they did	3
No help, despite seeking it from staff	4
Did not seek staff help	5
Had no financial problems	6

46. ☐

What do you suggest should be done today to help students with financial problems?

47. _____
_____
_____
_____

What academic problems did you encounter as a medical student at the University of Natal?

48. _____
_____
_____
_____

Did you approach any member of staff for assistance?

YES	N.A.	NO
1	2	

If not, why not? _____

49. _____
_____
_____

If yes, what form did the help take? _____

50. _____
_____
_____

If you did approach staff, what quality of help did you receive?

Effective help	1
Ineffective help - staff could have helped more	2
Ineffective help - staff could not have been expected to help more effectively than they did	3
No help, despite seeking it from staff	4
Did not seek staff help	5
Had no academic problems	6

51.

What do you suggest should be done today to help students with academic problems?

52. _____ ☐

_____

_____

_____

Where did you serve your internship? _____

53. _____ ☐

_____

_____

How long are you spending/did you spend in hospital service after the mandatory internship period in order to gain what you regarded as necessary experience not given during your internship?

54.

0 yrs.	1 yr.	1½ yrs	2 yrs.	3 + yrs.
5	1	2	3	4

☐

Why did you choose your particular hospital(s) for your internship? _____

55. _____ ☐

_____

_____

WHILE YOU WERE AN INTERN, WHAT WERE THE ATTITUDES OF HOSPITAL STAFF TOWARDS YOU? (IF THERE WERE DIFFERENCES BETWEEN HOSPITALS, SPECIFY; ALSO INDICATE IF RACIAL DIFFERENCES OCCURRED).

Your fellow interns? _____

56. _____ ☐

_____

_____

Your seniors? _____

57. _____ ☐

_____

_____

The nursing staff? _____

58. _____ ☐

_____

_____

From your experience, how many years should mandatory internship cover?

1 yr.	2 yrs.	D.K.
1	2	3

59. ☐

How do you think the time and content of the internship period should be arranged? _____

_____

_____

60. _____ ☐

_____

_____

PLEASE DESCRIBE IN SOME DETAIL THE TYPES OF PROBLEMS WHICH YOU FEEL A DOCTOR IN YOUR POSITION TYPICALLY HAS TO CONTEND WITH:

a) As an intern? _____

_____

61. _____ ☐

_____

62. _____ ☐

_____

b) In hospital service as a Medical Officer (or higher grade)? _____

_____

63. _____ ☐

_____

64. _____ ☐

_____

c) In private practice? _____

_____

65. _____ ☐

_____

66. _____ ☐

_____

Which of the above typical problems do you regard as the most serious?

67. _____ ☐

_____

_____

_____

Why? _____

68. _____ ☐

_____

_____

_____

From your experience, what suggestions have you to offer in regard to ways in which the Medical School can help future generations of students to be prepared for, or to avoid, the various problems which they are likely to encounter as doctors?

_____

_____

_____

69. _____ ☐

_____

_____

_____

70. _____ ☐

_____

_____

Can you elaborate on any of the problems you have been referring to. (<u>This section to be also used when coding previous details on problems</u>)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DETAILS OF HIS/HER CAREER SINCE GRADUATING WITH MB.B.Ch. FROM THE UNIVERSITY OF NATAL UP TO THE PRESENT:

(include post graduate studies and non-medical full-time jobs held since qualifying as a doctor).

	Dates	No.of years	Job Description title/and rank	Institution/ Employer	Town/ District	Reasons for Activity/Change involved (where training influenced decision, indicate this)	Problems Encountered at this Stage of Career (include professional and other problems associated with your career)
1							
2							
3							
4							
5							

NOTE: If respondent has stopped practising medicine, give reasons.

Which of your problems since graduating do you regard as the most important ones?

71. _____

_____

_____

_____

_____

To what extent had Medical School prepared you to meet all these problems you have been describing?

72.

Prepared me thoroughly	Prepared me	Prepared me only in part	Not prepared but should have	Did not, and could not be expected to, prepare me for such problems
1	2	3	4	5

Details: _____

_____

73. _____

_____

_____

In which of the positions you have held during your medical career did you obtain the greatest personal satisfaction?

74. _____

_____

Why? _____

_____

75. _____

_____

76. _____

_____

What gave you the greatest frustrations? _____

77. _____

_____

Why? _____

_____

78. _____

_____

79. _____

LIST THE NUMBER OF MEDICAL MEETINGS OF THE FOLLOWING TYPES YOU HAVE ATTENDED: (Indicate capacity in which you attended):

80. i) Overseas Conferences: No._____ ☐

Capacity attended:

81.

Organising Committee Member	Author	Official Delegate	Individual Member/ Observer	N.A.
1	2	3	4	5

☐

82. ii) South African Conferences: No. _____ ☐

Capacity attended:

83.

Organising Committee Member	Author	Official Delegate	Individual Member/ Observer	N.A.
1	2	3	4	5

☐

84. iii) Regional/Local Meetings of the Medical Association: No._____ ☐

Capacity attended:

85.

Organising Committee Member	Author	Official Delegate	Individual Member/ Observer	N.A.
1	2	3	4	5

☐

No. of professional (medical) publications you have to your credit as author or co-author:

86. Journal articles:_____ ☐

87. Books: _____ ☐

Awards, honours you have received:_____

88. _____ ☐

_____

_____

_____

SECTION APPLYING ONLY TO THOSE WHO ARE CURRENTLY IN PRIVATE PRACTICE

(If 'not applicable', go straight to page 20).

NOTE: IF NOT IN PRIVATE PRACTICE, FILL A ZERO IN IN ALL THE CODING BLOCKS.

Type of practice at present:

G.P. 1	Paediatrics 2	Surgery 3	Gynae. 4	Orthopaedics 5	Physician 6
Radiology 7	Anaesthetics 8	Other (Specify) _____			N.A. 0

89. ☐

90. How many years altogether have you been in private practice?_____ ☐

What made you choose your present (geographical) area for practice?_____

91. _____ ☐

_____

_____

What made you decide to enter private practice?_____

92. _____ ☐

_____

Have you ever regretted this decision?

YES 1	NO 2

93. ☐

Why? _____

_____

94. _____ ☐

_____

_____

If a specialist, why did you choose your particular field?

_____

_____

95. _____ ☐

_____

What are the frustrations and irritations you experience as a private practitioner?

96. _____

_____

_____

97. _____

_____

_____ [ ]

[ ]

Could you suggest changes in medical training to help equip one to deal with such frustrations?

98.

YES	NO IDEAS	CHANGES CAN'T HELP
1	2	3

[ ]

Details: _____

_____

99. _____

_____

_____ [ ]

What satisfactions do you derive from private practice?

_____

_____

100. _____

_____

101. _____

_____ [ ]

[ ]

How many patients, do you on average see daily?

	None	<5	5-9	10-19	20-29	30-39	40-49	50-59	60+	
102. All Races	1	2	3	4	5	6	7	8	9	[ ]
103. Whites	1	2	3	4	5	6	7	8	9	[ ]
104. Coloureds	1	2	3	4	5	6	7	8	9	[ ]
105. Indians	1	2	3	4	5	6	7	8	9	[ ]
106. Africans	1	2	3	4	5	6	7	8	9	[ ]

How many patients, on the average daily, do you operate on?

		None	<1	1-2	3-4	5-6	7-8	9-10	
107.	All Races	1	2	3	4	5	6	7	
108.	Whites	1	2	3	4	5	6	7	
109.	Coloureds	1	2	3	4	5	6	7	
110.	Indians	1	2	3	4	5	6	7	
111.	Africans	1	2	3	4	5	6	7	

With whom do you discuss day-to-day medical and professional problems?

112.	Partner(s) 1	Neighbouring doctor(s) in this area 2	Hospital staff 3	White doctors in town 4	Members of our regional Medical Assn. 5
	Other	No one 6			

If "other", specify _____

Is lack of contact with someone with whom you can discuss medical and professional difficulties a problem for you?

	YES	NO	N.A.
113.	1	2	3

Details: _____

114. _____

_____

_____

Do you experience difficulties over referring a patient to a specialist?

	YES	NO	N.A.
115.	1	2	3

Details: _____

116. _____

_____

_____

Do you experience difficulties/frustrations when referring a patient to hospital?

117.

YES FREQUENTLY	YES	SOMETIMES	NO
1		2	3

Details: _____

118. _____

_____

_____

When referring a patient do you give them a letter

a) to a specialist

119.

YES	NO
1	2

b) to hospital

120.

YES	NO
1	2

Comments: _____

121. _____

_____

_____

Do you try to follow up a patient referred to hospital?

122.

YES	NO
1	2

Details: _____

_____

123. _____

_____

_____

NOW GO TO PAGE 24 FOR SECTION ON 'FOLK MEDICINE AND KWASHIORKOR'

HOSPITAL SERVICE

This section applies only to those currently in Hospital Service.

(A code 0 throughout indicates no current Hospital Service).

Highest position achieved in hospital service:

124.

Intern	Medical Officer	Senior M.O.	Consultant	Senior Consultant	Head of a department	N.A.
1	2	3	4	5	6	0

How many years altogether have you been in hospital service?

125.

1 yr	2	3	4	5	6	7	8	9	10	11	12	13	14	15 or more yrs.
01	02	03	04	05	06	07	08	09	10	11	12	13	14	15

What made you decide to enter hospital service?

126. _____

_____

_____

_____

Have you regretted your decision?

127.

YES	NO	N.A.
1	2	0

Why? _____

128. _____

_____

_____

What made you choose this hospital for service?

129. _____

_____

_____

_____

In what department are you working now?

130.

Casualty	Surgery	Medical	Gynae.& Obstet.	Paediatrics	Pathol.
01	02	03	04	05	06

Eyes	E.N.T.	Outpatient	Other
07	08	09	

If other, specify:_____

What frustrations and irritations do you experience in hospital service?

131. _____

_____

_____

_____

132. _____

_____

Could you suggest changes in medical training to help equip one to deal with such frustrations?

133.

YES	NO	CHANGES CAN'T HELP
1	2	3

Details:_____

134. _____

_____

_____

What satisfactions do you derive from hospital service?

_____

_____

135. _____

_____

_____

136. _____

_____

How many patients daily do you on the average, in the department in which you are currently working

Examine?

137.

< 10	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+
1	2	3	4	5	6	7	8	9

☐

Operate on?

138.

< 10	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+
1	2	3	4	5	6	7	8	9

☐

HOW DO YOU FIND RELATIONS IN THIS HOSPITAL WITH THE FOLLOWING GRADES OF STAFF? WHERE NECESSARY GIVE DIFFERENCES OCCURRING BY RACE.

139. (a) Your superiors?_____ ☐

140. (b) Colleagues (Equal Rank)?_____ ☐

141. (c) Subordinates?_____ ☐

142. (d) Matron(s)?_____ ☐

143. (e) Para-medical Staff? _____ ☐

144. (f) Nursing Staff?_____ ☐

145. (g) Administrative Staff? _____

_____

_____

Do the administrators understand the problems you and your medical colleagues in the hospital have?

146.

YES	NO
1	2

Details: _____

_____

_____

_____

147. _____

_____

SECTION ON FOLK MEDICINE, AND KWASHIORKOR.

This, and the remaining sections of the interview, apply to all subjects.

LATER IN OUR OVERALL RESEARCH PROGRAMME WE INTEND TO STUDY FOLK MEDICINE AND THE ATTITUDE OF PATIENTS TOWARDS SCIENTIFIC MEDICINE. PERHAPS FROM YOUR OWN EXPERIENCE YOU COULD HELP US WITH THIS PART OF OUR STUDY: FROM TIME TO TIME YOU MUST COME ACROSS PATIENTS WITH TRADITIONAL NON-WESTERN IDEAS OF THE CAUSATION OF DISEASE, WHO CLING TO 'FOLK MEDICINE':

FROM YOUR EXPERIENCE, WHAT ASPECTS OF FOLK MEDICINE - I.E. TRADITIONAL REMEDIES, HEALTH PRACTICES, BELIEFS AND THEIR EFFECTS - DO YOU CONSIDER TO BE OF PRACTICAL VALUE?

148. ---------- ☐

Why? ----------

149. ---------- ☐

Can such aspects be integrated into the practice of scientific medicine?

150.

YES	YES IN PART	MAYBE	NO	D.K.
1	2	3	4	5

☐

Some authorities appear convinced that in certain cases it is necessary (for psychological or other reasons) to allow traditional folk medicine and scientific medicine side by side.

Do you

151.

AGREE STRONGLY	AGREE	D.K.	DISAGREE	DISAGREE STRONGLY
1	2	3	4	5

☐

Reasons and Details:_____

_____

152. _____ ☐

_____

If you agree, how do you think this should be done?

_____

_____

153. _____ ☐

_____

Do you attempt to integrate some aspects of folk medicine into your own work?

YES	NO
1	2

154. ☐

Details:_____

_____

155. _____ ☐

_____

Have you come across case(s) where folk medicine has helped a patient after formal medicine has failed?

YES	NO
1	2

156. ☐

If YES, please tell me about it:_____

_____

_____

157. _____ ☐

_____

_____

How do you allay the anxieties and fears of a patient who sees his/her illness in terms of traditional folk explanations?

_____

_____

_____

158. _____ ☐

_____

_____

Doctors not infrequently are confronted with the patient who demands an injection regardless of the nature of his complaint.

Could you tell us more about this type?

159. _____ ☐

_____

_____

_____

How do you handle this type of request?

160. _____ ☐

_____

_____

_____

_____

_____

Some patients apparently expect a doctor to behave like a diviner and tell them their complaints without asking questions.

Have you experienced this?

161.

YES	NO
1	2

☐

If YES, tell me more about this type of patient:

162. _____ ☐

_____

_____

_____

_____

_____

_____

How do you handle this situation? _____

163. _____ ☐

_____

_____

_____

_____

_____

Does it worry you if you know or suspect a patient is also consulting a traditional diviner about his/her illness?

164.

YES	NO
1	2

Why? _____

_____

165. _____

_____

Have you within the last year had to treat patients suffering from pellagra or kwashiorkor?

166.

YES	NO
1	2

What % of your patients?

167.

None	<10	10-19	20-29	30-39	40-49	50+
1	2	3	4	5	6	7

What percentage of your patients do you consider to be malnourished?

168.

<10	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+
1	2	3	4	5	6	7	8	9

Typically how do you handle a malnourished/kwashiorkor/pellagra patient? (Probe to make sure if something is done to educate patient and to try to improve home conditions.)

_____

_____

_____

_____

169. _____

_____

To what extent did the Medical School train you to deal with such cases?

170.

ADEQUATELY	INADEQUATELY
1	2

Comments _____

171. _____ ☐

ATTITUDES, ASPIRATIONS AND GOALS.

THIS SECTION APPLIES TO ALL CASES.

Describe in order of importance, the qualities of your ideal doctor as you see him now:

172. _____ ☐

173. _____ ☐

174. _____ ☐

175. _____ ☐

In what way does this picture differ from the image of a doctor you had before entering Medical School?

176. _____ ☐

How did your 'varsity training shape your picture of the ideal doctor?

177. _____ ☐

How has your experience altered this picture?

178. ---

FOR HOSPITAL STAFF: How do your hospital superiors conform to this ideal?

179. ---

FOR ALL SUBJECTS: How do your colleagues conform to this ideal?

180. ---

There are many and varied types of doctors. What type of doctor do you think Natal's Medical School should aim to produce, given the type of medical cases they have to treat?

181. ---

Describe your ideal patient:

182. ---

183. ---

184. ---

By contrast, what is your average patient like?

185. _____ ☐

_____

_____

_____

186. _____ ☐

What frustrations and irritations do you experience with patients?

187. _____ ☐

_____

_____

_____

188. _____ ☐

Ideally, what responsibilities does a doctor have towards his patient? (Make sure of a full reply)

189. _____ ☐

_____

190. _____ ☐

_____

191. _____ ☐

Do you find, in actual experience, under day-to-day working conditions you can fulfill these responsibilities? (Be explicit)

_____

_____

192. _____ ☐

_____

_____

What information do you think a doctor needs to know about a patient in order to treat him effectively?

_____

_____

193. _____ ☐

_____

_____

Would you recommend medicine as a career to an intelligent and ambitious

	YES	MAYBE DEPENDS	NO	D.K.	
194. a) Young African man?	1	2	3	4	☐
195. b) Young Indian man?	1	2	3	4	☐
196. c) Young Coloured man?	1	2	3	4	☐

Reasons for replies ... :

197. a) When African ---------- ☐

---

198. b) When Indian ---------- ☐

---

199. c) When Coloured ---------- ☐

Would you recommend medicine as a career to an intelligent and ambitious

	YES	MAYBE DEPENDS	NO	D.K.	
200. a) Young African woman?	1	2	3	4	☐
201. b) Young Indian woman?	1	2	3	4	☐
202. c) Young Coloured woman?	1	2	3	4	☐

Reasons for replies

203. a) When African ---------- ☐

---

204. b) When Indian ---------- ☐

---

205. c) When Coloured ---------- ☐

If you could start your life again, and had a free choice, would you choose medicine a second time?

	YES	MAYBE	NO	D.K.	
206.	1	2	3	4	☐

Why?_____

207. _____ ☐
_____
_____

Would you do the same things again? (e.g. be G.P., or Hospital Service, etc.)

YES	MAYBE	NO	D.K.
1	2	3	4

208. ☐

Why?_____

209. _____ ☐
_____
_____

What are your future plans?

G.P.	1
Specialise	2
Hospital Service	3
Overseas Practice	4
Elsewhere in Africa	5
Higher Degrees in S.A.	6
Higher Degrees Overseas	7
Give up Medicine	8

210. ☐

Reasons: _____

211. _____ ☐
_____
_____

What were your long-term intentions when you started your career after leaving Medical School?

_____

212. _____ ☐
_____
_____

What problems and difficulties do you experience in keeping abreast of medical development and knowledge? (PROBE FULLY).

213. _____ ☐

_____

_____

_____

_____

_____

Journals you subscribe to: _____

214. _____ ☐

_____

_____

_____

_____

_____;

Journals you regularly borrow: _____

215. _____ ☐

_____

_____

_____

_____

_____

Who do you borrow journals from?

217.

COLLEAGUES	HOSPITAL	PUBLIC LIBRARY	MEDICAL SCHOOL LIBRARY	N.A.	OTHER
1	2	3	4	5	

☐

If other, specify: _____

_____

_____

Does the Medical Association help you to keep abreast?

218.

YES	NO
1	2

☐

If YES, how? _____

219. _____ ☐

_____

_____

If not, should it help?

YES	NO	N.A.
1	2	3

220 ☐

If YES, how? _____

_____

221. _____ ☐

_____

How many hours per month do you, on average, manage to devote to continuing your self-education and study (reading, discussing problems with experts, etc.)?

222. ..... _____ ☐

What aspects of the expected professional and personal behaviour of a doctor do you find:

Distasteful? _____

_____

223. _____ ☐

_____

Frustrating? _____

_____

224. _____ ☐

_____

From your knowledge, to what extent are the following forms of behaviour exhibited by doctors, and why?

Alcoholic Abuse? (i) Extent: _____

_____

225. _____ ☐

_____

(ii) Reason why you believe they behave in this way. (If there are social problems which might aggravate the problem, state them.)

_____

_____

226. _____ ☐

_____

Drugs Abuse? (i) Extent: _____

227. _____ ☐

_____

_____

(ii) Reasons why they resort to drugs? (If there are social problems which might aggravate the problem, state them).

_____

228. _____ ☐

_____

_____

Sexual Promiscuity and/or Extra-Premarital Sex:

(i) Extent: _____

229. _____ ☐

_____

_____

(ii) Reasons why they behave in this way? (Include social problems, if any, you think may aggravate this behaviour).

_____

230. _____ ☐

_____

_____

Are any particular types of doctors, or particular medical school graduates more prone to these problems than others?

YES	NO	D.K.
1	2	3

231. ☐

If YES, specify: _____

232. _____ ☐

_____

_____

If so, why do you think this is so?

_____

233. _____ ☐

_____

_____

PERSONAL AND HOUSEHOLD DATA.

AGE, in years, at last birthday:

234.

< 25	25-29	30-34	35-39	40-49	50-54	55-59	60+
1	2	3	4	5	6	7	8

RACE:

235.

AFRICAN	COLOURED	INDIAN	CHINESE
1	2	3	4

SEX:

236.

MALE	FEMALE
1	2

MARITAL STATUS:

237.

NEVER MARRIED	MARRIED	LIVING TOGETHER	WIDOW/ER	DIVORCED	SEPARATED
1	2	3	4	5	6

If married, your current marriage was by:

238.

RELIGIOUS CEREMONY ONLY	1
CIVIL CEREMONY ONLY	2
CUSTOMARY UNION ONLY	3
RELIGIOUS & CIVIL CEREMONY	4
CUSTOMARY UNION & CIVIL	5
N.A.	6

Did you give bridewealth for your wife (or if a woman, was bridewealth given for you)?

239.

YES	NO	NOT MARRIED
1	2	3

AGE <u>first</u> married, in years:

240.

< 25	20-24	25-29	30-34	35-39	40-44	45+	NOT MARRIED
1	2	3	4	5	6	7	8

THE PRESENT WIFE/HUSBAND IS

241.

1st	2nd	3rd	NOT MARRIED
1	2	3	4

If married more than once, previous marriage(s) were ended as follows:

	DIVORCE	DEATH
242. First marriage	1	2
243. Second marriage	1	2
244. Third marriage	1	2

FIRST MARRIED

245.

BEFORE	DURING	AFTER	N.A.
1	2	3	4

MEDICAL TRAINING

PLACE OF BIRTH: i.e. Normal residence of Mother at time of birth:

246.

BANTU RESERVE	1
MISSION RESERVE	2
FARM	3
TOWN	4
D.K.	5

NAME OF AREA where Mother normally resided at time of birth:

247. DISTRICT: _____

TOWN: _____

PLACE SUBJECT SPENT MOST OF CHILDHOOD:

248. Name: DISTRICT:_____TOWN:_____

Type of Area:

249.

BANTU RESERVE	MISSION RESERVE	FARM	TOWN
1	2	3	4

Highest educational level attained before going to Medical School:

250.

MATRIC OR STD.10	1ST YEAR UNIV.	2ND YEAR UNIV.	BACHELOR'S DEGREE	HONOURS DEGREE	MASTER'S DEGREE
1	2	3	4	5	6

☐

Did you go direct to Medical School from University/School?

251.

YES	NO
1	2

☐

If NO, what did you do first? _____

252. _____

_____ ☐

Why? _____

253. _____

_____ ☐

_____

HIGHEST MEDICAL EDUCATIONAL LEVEL ATTAINED:

254.

MB. B.Ch.	M.M. or M.Ch.	Ph.D.	M.D.
1	2	3	4

☐

AGE ENTERED MEDICAL SCHOOL:

255.

YEARS													
16	17	18	19	20	21	22	23	24	25-29	30-34	35-39	40-44	45+
01	02	03	04	05	06	07	08	09	10	11	12	13	14

☐

How did you finance your training?

256. _____

_____

_____ ☐

_____

AGE WHEN YOU COMPLETED MEDICAL SCHOOL TRAINING:

257.

<25	25-29	30-34	35-39	40-44	45-49	50+
1	2	3	4	5	6	7

☐

RELIGIOUS AFFILIATION:

258.	TRAD. AFRICAN 1	HINDU 2	MUSLIM 3	PARSEE 4	CHRISTIAN 5	AGNOSTIC 6	ATHEIST 7

IF CHRISTIAN, DENOMINATION OR SECT:

259. ----------

If CHRISTIAN, how often did you go to church during the past month?

260. ----------

MEMBERSHIP OF CLUBS, ASSOCIATIONS, RELIGIOUS ORGANISATIONS, ETC. (include professional, social, welfare, sporting and other bodies):

261. ----------

262. ----------

263. ----------

OFFICES HELD IN CLUBS, ASSOCIATIONS, CHURCH, ETC.:

264. ----------

265. ----------

266. ----------

HIGHEST EDUCATIONAL LEVEL ATTAINED BY YOUR SPOUSE:

267.	<STD.6 01	STD.7-8 02	STD.9 03	MATRIC/ STD.10 04	1ST/2ND YEAR UNIV. 05	BACHELOR'S DEGREE 06	HONOURS DEGREE 07
	MASTER'S DEGREE 08	MB. B.Ch. 09	OTHER (specify) ----------				NO SPOUSE 00

PROFESSIONAL TRAINING OBTAINED BY SPOUSE:

268.

NONE	MEDICINE	NURSING	TEACHING	SOCIAL WORK	LAW	OTHER	NO SPOUSE
1	2	3	4	5	6		0

If OTHER, specify:_____

PRESENT OCCUPATION OF SPOUSE (indicate also if part-time, full-time, temporary):

269. _____

OCCUPATION OF SPOUSE PRIOR TO MARRIAGE:

270. _____

OCCUPATION OF YOUR FATHER. (If deceased, or retired also give last gainful occupation).

271. _____

OCCUPATION OF YOUR MOTHER. (If deceased or retired also give last gainful occupation).

272. _____

HIGHEST EDUCATIONAL LEVEL ATTAINED BY YOUR

273. FATHER:_____

274. MOTHER:_____

275. NUMBER OF YOUR CHILDREN (ALIVE): ☐

DETAILS OF PERSONS OTHER THAN YOUR FAMILY OF PROCREATION WHO ARE PARTIALLY/WHOLLY DEPENDENT ON YOU. (Include persons he/she is assisting with their education).

276. _____
_____

277. _____
_____

278. _____
_____

Do your wife and children live with you?

279.

YES	NO	NOT MARRIED
1	2	3

☐

If NO, why not? _____

_____

280. _____

_____

☐

If NO, how often do you see your wife/and children?

281. ☐ per week/month/year ☐

ONLY FOR GRADUATES OUTSIDE THE BORDERS OF SOUTH AFRICA.

What made you decide to leave South Africa and practise where you are now?

_____

_____

_____

282. _____

_____

_____

☐

Do you ever plan to return to South Africa to practise medicine and why?

_____

_____

_____

283. _____

_____

_____

☐

Any Notes/Comments by Fieldworker:

INSTITUTE FOR SOCIAL RESEARCH
UNIVERSITY OF NATAL

STRICTLY CONFIDENTIAL

Schedule No. [ ]

STUDY OF THE MEDICAL SCHOOL OF
THE UNIVERSITY OF NATAL

PLEASE COMPLETE THE FOLLOWING 28 SENTENCES AS QUICKLY AS POSSIBLE. PUT DOWN THE FIRST IDEA WHICH COMES INTO YOUR HEAD, REGARDLESS OF WHAT IT IS.

1. Doctoring_____
_____

2. The University of Natal Medical School_____
_____

3. Private practice_____
_____

4. If I could choose_____
_____

5. Hospitals_____
_____

6. I hate_____
_____

7. Drugs offer_____
_____

8. The greatest pleasure_____
_____

9. Patients_____
_____

10. White_____

_____

11. Being a specialist_____

_____

12. Caught between_____

_____

13. I hope_____

_____

14. I admire_____

_____

15. I wish I could be _____

_____

16. I feel angry_____

_____

17. A nice day_____

_____

18. I feel helpless_____

_____

19. It seems I can never_____

_____

20. Between you and me _____

_____

21. Other people_____

_____

22. The thing about drink is _____

_____

23. Authority_____

_____

24. Women_____

_____

25. More than_____

_____

26. A sense of frustration_____

_____

27. If only_____

_____

28. Down_____

_____

STRICTLY CONFIDENTIAL

SCHEDULE NO. [ ]

INSTITUTE FOR SOCIAL RESEARCH

UNIVERSITY OF NATAL

STUDY OF GRADUATES

OF THE UNIVERSITY OF NATAL

MEDICAL SCHOOL

SEMANTIC DIFFERENTIAL

Please rate the following concepts in terms of the scales provided. Work as quickly as you can without deliberate reflection, putting a cross in that space between each pair of adjectives which at first glance you think appropriate. You will see that you can, by choosing a particular space, show the direction and intensity of your idea. e.g.

GOOD ___ ___ ___ X ___ ___ ___ BAD. This shows a rather neutral or mid position - neither good or bad.

Or again,

GOOD ___ ___ ___ ___ ___ ___ X BAD would indicate 'very bad' and so on.

This task is NOT supposed to take much of your time, and it is emphasised you must work as quickly as you can, 'galloping' through the ratings. You are not expected to know answers - there are no right or wrong answers. Just fill in your reaction, and please do not miss out any items.

SEMANTIC DIFFERENTIAL

Concept: UNIVERSITY OF NATAL MEDICAL SCHOOL

GOOD	___:	___:	___:	___:	___:	___:	___:	BAD
IMPORTANT	___:	___:	___:	___:	___:	___:	___:	UNIMPORTANT
FALSE	___:	___:	___:	___:	___:	___:	___:	TRUE
UNSUCCESSFUL	___:	___:	___:	___:	___:	___:	___:	SUCCESSFUL
KIND	___:	___:	___:	___:	___:	___:	___:	CRUEL
PASSIVE	___:	___:	___:	___:	___:	___:	___:	ACTIVE
PROBLEM FREE	___:	___:	___:	___:	___:	___:	___:	PROBLEM RIDDEN
DISORGANISED	___:	___:	___:	___:	___:	___:	___:	ORGANISED
FULL OF IDEALS	___:	___:	___:	___:	___:	___:	___:	LACKING IDEALS
REALISTIC	___:	___:	___:	___:	___:	___:	___:	UNREALISTIC
INCOMPETENT	___:	___:	___:	___:	___:	___:	___:	COMPETENT
UNPREJUDICED	___:	___:	___:	___:	___:	___:	___:	BIGOTED
UNFAIR	___:	___:	___:	___:	___:	___:	___:	FAIR
PROGRESSIVE	___:	___:	___:	___:	___:	___:	___:	CONSERVATIVE
BEST	___:	___:	___:	___:	___:	___:	___:	WORST
STUPID	___:	___:	___:	___:	___:	___:	___:	CLEVER
UNTRUSTWORTHY	___:	___:	___:	___:	___:	___:	___:	TRUSTWORTHY
SATISFYING	___:	___:	___:	___:	___:	___:	___:	FRUSTRATING

SEMANTIC DIFFERENTIAL

Concept: AFRICAN DOCTORS

GOOD	___:	___:	___:	___:	___:	___:	___: BAD
IMPORTANT	___:	___:	___:	___:	___:	___:	___: UNIMPORTANT
FALSE	___:	___:	___:	___:	___:	___:	___: TRUE
UNSUCCESSFUL	___:	___:	___:	___:	___:	___:	___: SUCCESSFUL
KIND	___:	___:	___:	___:	___:	___:	___: CRUEL
GOOD IN AN EMERGENCY	___:	___:	___:	___:	___:	___:	___: HOPELESS IN AN EMERGENCY
PASSIVE	___:	___:	___:	___:	___:	___:	___: ACTIVE
PROBLEM FREE	___:	___:	___:	___:	___:	___:	___: PROBLEM RIDDEN
DISORGANISED	___:	___:	___:	___:	___:	___:	___: ORGANISED
FULL OF IDEALS	___:	___:	___:	___:	___:	___:	___: LACKING IDEALS
REALISTIC	___:	___:	___:	___:	___:	___:	___: UNREALISTIC
RESPONSIBLE	___:	___:	___:	___:	___:	___:	___: IRRESPONSIBLE
INCOMPETENT	___:	___:	___:	___:	___:	___:	___: COMPETENT
UNPREJUDICED	___:	___:	___:	___:	___:	___:	___: BIGOTED
UNFAIR	___:	___:	___:	___:	___:	___:	___: FAIR
PROGRESSIVE	___:	___:	___:	___:	___:	___:	___: CONSERVATIVE
BEST	___:	___:	___:	___:	___:	___:	___: WORST
STUPID	___:	___:	___:	___:	___:	___:	___: CLEVER
UNTRUSTWORTHY	___:	___:	___:	___:	___:	___:	___: TRUSTWORTHY
SATISFIED	___:	___:	___:	___:	___:	___:	___: FRUSTRATED

SEMANTIC DIFFERENTIAL

Concept: WITS. MEDICAL SCHOOL

GOOD	___:	___:	___:	___:	___:	___:	___:	BAD
UNIMPORTANT	___:	___:	___:	___:	___:	___:	___:	IMPORTANT
FALSE	___:	___:	___:	___:	___:	___:	___:	TRUE
UNSUCCESSFUL	___:	___:	___:	___:	___:	___:	___:	SUCCESSFUL
CRUEL	___:	___:	___:	___:	___:	___:	___:	KIND
ACTIVE	___:	___:	___:	___:	___:	___:	___:	PASSIVE
PROBLEM FREE	___:	___:	___:	___:	___:	___:	___:	PROBLEM RIDDEN
DISORGANISED	___:	___:	___:	___:	___:	___:	___:	ORGANISED
LACKING IDEALS	___:	___:	___:	___:	___:	___:	___:	FULL OF IDEALS
REALISTIC	___:	___:	___:	___:	___:	___:	___:	UNREALISTIC
COMPETENT	___:	___:	___:	___:	___:	___:	___:	INCOMPETENT
BIGOTED	___:	___:	___:	___:	___:	___:	___:	UNPREJUDICED
UNFAIR	___:	___:	___:	___:	___:	___:	___:	FAIR
CONSERVATIVE	___:	___:	___:	___:	___:	___:	___:	PROGRESSIVE
BEST	___:	___:	___:	___:	___:	___:	___:	WORST
STUPID	___:	___:	___:	___:	___:	___:	___:	CLEVER
UNTRUSTWORTHY	___:	___:	___:	___:	___:	___:	___:	TRUSTWORTHY
FRUSTRATING	___:	___:	___:	___:	___:	___:	___:	SATISFYING

SEMANTIC DIFFERENTIAL

Concept: THE HOSPITAL WHERE I TRAINED

GOOD	___:	___:	___:	___:	___:	___:	___: BAD
IMPORTANT	___:	___:	___:	___:	___:	___:	___: UNIMPORTANT
FALSE	___:	___:	___:	___:	___:	___:	___: TRUE
UNSUCCESSFUL	___:	___:	___:	___:	___:	___:	___: SUCCESSFUL
KIND	___:	___:	___:	___:	___:	___:	___: CRUEL
PASSIVE	___:	___:	___:	___:	___:	___:	___: ACTIVE
PROBLEM FREE	___:	___:	___:	___:	___:	___:	___: PROBLEM RIDDEN
DISORGANISED	___:	___:	___:	___:	___:	___:	___: ORGANISED
FULL OF IDEALS	___:	___:	___:	___:	___:	___:	___: LACKING IDEALS
REALISTIC	___:	___:	___:	___:	___:	___:	___: UNREALISTIC
INCOMPETENT	___:	___:	___:	___:	___:	___:	___: COMPETENT
UNPREJUDICED	___:	___:	___:	___:	___:	___:	___: BIGOTED
UNFAIR	___:	___:	___:	___:	___:	___:	___: FAIR
PROGRESSIVE	___:	___:	___:	___:	___:	___:	___: CONSERVATIVE
BEST	___:	___:	___:	___:	___:	___:	___: WORST
STUPID	___:	___:	___:	___:	___:	___:	___: CLEVER
UNTRUSTWORTHY	___:	___:	___:	___:	___:	___:	___: TRUSTWORTHY
SATISFYING	___:	___:	___:	___:	___:	___:	___: FRUSTRATING

SEMANTIC DIFFERENTIAL

Concept: WHITE DOCTORS

BAD	___:	___:	___:	___:	___:	___:	___:	GOOD
IMPORTANT	___:	___:	___:	___:	___:	___:	___:	UNIMPORTANT
TRUE	___:	___:	___:	___:	___:	___:	___:	FALSE
UNSUCCESSFUL	___:	___:	___:	___:	___:	___:	___:	SUCCESSFUL
CRUEL	___:	___:	___:	___:	___:	___:	___:	KIND
ACTIVE	___:	___:	___:	___:	___:	___:	___:	PASSIVE
GOOD IN AN EMERGENCY	___:	___:	___:	___:	___:	___:	___:	HOPELESS IN AN EMERGENCY
PROBLEM RIDDEN	___:	___:	___:	___:	___:	___:	___:	PROBLEM FREE
ORGANISED	___:	___:	___:	___:	___:	___:	___:	DISORGANISED
FULL OF IDEALS	___:	___:	___:	___:	___:	___:	___:	LACKING IDEALS
REALISTIC	___:	___:	___:	___:	___:	___:	___:	UNREALISTIC
IRRESPONSIBLE	___:	___:	___:	___:	___:	___:	___:	RESPONSIBLE
COMPETENT	___:	___:	___:	___:	___:	___:	___:	INCOMPETENT
UNPREJUDICED	___:	___:	___:	___:	___:	___:	___:	BIGOTED
FAIR	___:	___:	___:	___:	___:	___:	___:	UNFAIR
PROGRESSIVE	___:	___:	___:	___:	___:	___:	___:	CONSERVATIVE
WORST	___:	___:	___:	___:	___:	___:	___:	BEST
CLEVER	___:	___:	___:	___:	___:	___:	___:	STUPID
UNTRUSTWORTHY	___:	___:	___:	___:	___:	___:	___:	TRUSTWORTHY
SATISFIED	___:	___:	___:	___:	___:	___:	___:	FRUSTRATED

SEMANTIC DIFFERENTIAL

Concept: MY PATIENTS

GOOD	___:	___:	___:	___:	___:	___:	___: BAD
IMPORTANT	___:	___:	___:	___:	___:	___:	___: UNIMPORTANT
FALSE	___:	___:	___:	___:	___:	___:	___: TRUE
UNSUCCESSFUL	___:	___:	___:	___:	___:	___:	___: SUCCESSFUL
KIND	___:	___:	___:	___:	___:	___:	___: CRUEL
PASSIVE	___:	___:	___:	___:	___:	___:	___: ACTIVE
PROBLEM FREE	___:	___:	___:	___:	___:	___:	___: PROBLEM RIDDEN
DISORGANISED	___:	___:	___:	___:	___:	___:	___: ORGANISED
FULL OF IDEALS	___:	___:	___:	___:	___:	___:	___: LACKING IDEALS
REALISTIC	___:	___:	___:	___:	___:	___:	___: UNREALISTIC
RESPONSIBLE	___:	___:	___:	___:	___:	___:	___: IRRESPONSIBLE
INCOMPETENT	___:	___:	___:	___:	___:	___:	___: COMPETENT
UNPREJUDICED	___:	___:	___:	___:	___:	___:	___: BIGOTED
UNFAIR	___:	___:	___:	___:	___:	___:	___: FAIR
PROGRESSIVE	___:	___:	___:	___:	___:	___:	___: CONSERVATIVE
BEST	___:	___:	___:	___:	___:	___:	___: WORST
STUPID	___:	___:	___:	___:	___:	___:	___: CLEVER
UNTRUSTWORTHY	___:	___:	___:	___:	___:	___:	___: TRUSTWORTHY
SATISFYING	___:	___:	___:	___:	___:	___:	___: FRUSTRATING

SEMANTIC DIFFERENTIAL

Concept: INDIAN DOCTORS

BAD	___:	___:	___:	___:	___:	___:	___:	GOOD
IMPORTANT	___:	___:	___:	___:	___:	___:	___:	UNIMPORTANT
FALSE	___:	___:	___:	___:	___:	___:	___:	TRUE
SUCCESSFUL	___:	___:	___:	___:	___:	___:	___:	UNSUCCESSFUL
KIND	___:	___:	___:	___:	___:	___:	___:	CRUEL
GOOD IN AN EMERGENCY	___:	___:	___:	___:	___:	___:	___:	HOPELESS IN AN EMERGENCY
ACTIVE	___:	___:	___:	___:	___:	___:	___:	PASSIVE
PROBLEM RIDDEN	___:	___:	___:	___:	___:	___:	___:	PROBLEM FREE
DISORGANISED	___:	___:	___:	___:	___:	___:	___:	ORGANISED
FULL OF IDEALS	___:	___:	___:	___:	___:	___:	___:	LACKING IDEALS
REALISTIC	___:	___:	___:	___:	___:	___:	___:	UNREALISTIC
RESPONSIBLE	___:	___:	___:	___:	___:	___:	___:	IRRESPONSIBLE
INCOMPETENT	___:	___:	___:	___:	___:	___:	___:	COMPETENT
BIGOTED	___:	___:	___:	___:	___:	___:	___:	UNPREJUDICED
FAIR	___:	___:	___:	___:	___:	___:	___:	UNFAIR
CONSERVATIVE	___:	___:	___:	___:	___:	___:	___:	PROGRESSIVE
BEST	___:	___:	___:	___:	___:	___:	___:	WORST
CLEVER	___:	___:	___:	___:	___:	___:	___:	STUPID
TRUSTWORTHY	___:	___:	___:	___:	___:	___:	___:	UNTRUSTWORTHY
SATISFIED	___:	___:	___:	___:	___:	___:	___:	FRUSTRATED

INSTITUTE FOR SOCIAL RESEARCH ISR.16/71
UNIVERSITY OF NATAL

TELEPHONE: 35-9852
TELEGRAMS: "UNIVERSITY"

KING GEORGE V AVENUE,
DURBAN,
REPUBLIC OF SOUTH AFRICA.

OUR REFERENCE:..... 110.

10 August 1971

SURVEY OF GRADUATES OF THE MEDICAL SCHOOL
OF THE UNIVERSITY OF NATAL.

A Study in the Field of the Sociology of Education.

QUESTIONNAIRE TO GRADUATES, 1971

STRICTLY CONFIDENTIAL.

Dear Doctor,

As you may know, several evaluative sociological studies into medical training and the problems of medical practitioners have been undertaken in America. The results of such studies have proved valuable to the medical schools concerned in guiding their future training of students. At the University of Natal, the Medical School has asked the Institute for Social Research to undertake such a study. Staff and students of the School have already been interviewed, as well as a random sample of graduates. Now this questionnaire is going out to the remaining graduates. The questionnaire is completely confidential. It gives you an opportunity to express your assessment of the University of Natal Medical School and the training you received, and to make criticisms and suggestions. In giving an indication of your career and the problems you have experienced, you will help to provide a picture of the extent to which past training has prepared students for their careers. All this information will, in turn, assist in moulding the training of future graduates of the School.

I realize this lengthy questionnaire is an imposition on the time of you, a busy professional worker. However, important matters cannot be disposed of briefly. I sincerely hope you will assist by filling in the questionnaire carefully and returning it to me. Only by receiving replies from all graduates can we hope to build up a true picture to guide the University's Medical School. So it is I appeal to you to co-operate with the survey, and must stress the value of your assistance.

Thank you for the time and thought you will devote to completing the questionnaire.

Yours sincerely,

H.L. Watts.

H.L. WATTS
Director

When completing the following questions please write legibly. Where a choice of "boxed" answers is provided for you, indicate your answer by making a bold cross *in the box which applies.*

For Office Use.

1. What is the nature of your current practice?

Intern	Hospital Service	G.P.	Specialist in private practice	Teaching	Further Study in S.A.	Further Study overseas
01	02	03	04	05	06	07

G.P. and part-time hospital work	Specialist and part-time hospital work	Retired	Given up medical practice
08	09	10	11

☐

2. Name of the area where you practise

Town: .....

District: .....

Country: .....

☐

3. What made you decide to take up medicine? .

.....

.....

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.....

.....

☐

☐

4. Looking back on your training at the University of Natal Medical School, what comments do you have to make about it? In your assessment, please give criticisms and constructive suggestions for improvement. Not only think about training in general, but also about specific aspects such as the teaching of theory, laboratory and clinical work, the content, sequence and balance of courses, work load, and staff-student relations on which you may deem it necessary to comment:

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continued over page

For Office Use

4. (continued)

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5. Do you feel that there were important omissions in your training?

Yes	No
1	2

6. If "yes", please give details of these omissions:

.....

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.....

7. If subsequent to being at the University of Natal, you have studied/worked at another medical school, please give the name(s) of the school(s) concerned:

.....

.....

8. How did the University of Natal School compare with this/these medical school(s)?

Favourably	Much the same	Poorly	Not sure	Not applicable
1	2	3	4	5

Reasons (if you wish): .....

.....

.....

9. Generally speaking, how do you think the University of Natal Medical School compares with other South African Medical Schools?

Favourably	Much the same	Poorly
1	2	3

Reasons (if you wish): .....

.....

.....

continued over page

For Office Use

9. (continued)

Overseas medical schools?

Favourably 1	Much the same 2	Poorly 3

Reasons (if you wish): .....

.....

.....

10. Students usually experience some problems. What kinds of problems did you experience as a medical student at the University of Natal? (Think back not only to financial problems, but also personal/inter-personal and academic problems).

.....

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.....

.....

11. From whom did you seek assistance with these problems?

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.....

12. If you sought assistance from members of staff, comment on the quality and effectiveness of the help received:

.....

.....

.....

.....

13. If you did not seek help from anyone, why not?

.....

.....

.....

.....

For Office Use

14. What do you suggest should be done today to help students with similar problems?

.....
.....
.....
.....
.....
.....

15. At present the mandatory internship period in South Africa is one year. How long do you think it should be?

Under one year	One year	1½ years	2 years	2½ years	3+ years
1	2	3	4	5	6

16. How do you suggest the time and content of this internship should be arranged?

.....
.....
.....
.....
.....
.....
.....

17. Where did you serve your internship?

.....

18. Indicate how, during your internship, you found the attitudes of different types of hospital staff towards you. Refer to any problems you experienced in this regard. Where racial differences were evident, please specify.

Your fellow interns:

.....
.....
.....
.....

continued over page

For Office Use

18.(continued)

Your seniors:

.....

.....

.....

.....

Nursing staff:

.....

.....

.....

.....

19. The following pages 6 - 11 ask for details of your career, and the problems, satisfactions and frustrations you experienced at each stage. Please provide full details; using one page per job. Allowance is made for six job changes after internship. If you have had more than six changes, please fill the additional information in on extra sheets of paper and pin them to the questionnaire. If you have had less than six, please rule through the pages you do not require:-

For Office Use

19. Details of your <u>first job</u> after completing your internship.

i) Job description including title and rank:

.....

ii) Institution or employer:

.....

iii) Town or district concerned (and country if not S.Africa):

.....

iv) Number of years held this job:

.....

v) Dates concerned:

.....

vi) Reasons for taking up this position (please indicate if your training influenced your decision):

.....

.....

vii) The typical problems/frustrations you encountered at this stage of your career:

.....

.....

.....

.....

.....

viii) To what extent did the Medical School prepare you for these problems/frustrations?

Adequately	Inadequately	Not at all
1	2	3

ix) What changes in training (if any) would you suggest to prepare future graduates for such problems/frustrations?

.....

.....

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.....

.....

x) Indicate changes (of whatever kind you deem fit) which could prevent such problems/frustrations:

.....

.....

.....

.....

xi) What satisfactions did this part of your career give?

.....

.....

.....

xii) Have you ever regretted this stage of your career?

Yes	No
1	2

If yes, why? .....

.....

.....

For Office Use

20. Details of your second job after completing your internship.

i) Job description including title and rank:

.....

ii) Institution or employer:

.....

iii) Town or district concerned (and country if not S.Africa)

.....

iv) Number of years held this job:

.....

v) Dates concerned:

.....

vi) Reasons for taking up this position (please indicate if your training influenced your decision):

.....

.....

vii) The typical problems/frustrations you encountered at this stage of your career:

.....

.....

.....

.....

.....

viii) To what extent did the Medical School prepare you for these problems/frustrations?

Adequately 1	Inadequately 2	Not at all 3

ix) What changes in training (if any) would you suggest to prepare future graduates for such problems/frustrations?

.....

.....

.....

.....

.....

x) Indicate changes (of whatever kind you deem fit) which could prevent such problems/frustrations:

.....

.....

.....

.....

.....

xi) What satisfactions did this part of your career give?

.....

.....

.....

xii) Have you ever regretted this stage of your career? Yes 1 | No 2

If yes, why? .....

.....

For Office Use

21. Details of your third job after completing your internship.

i) Job description including title and rank:

.....

ii) Institution or employer:

.....

iii) Town or district concerned (and country if not S.Africa)

.....

iv) Number of years held this job:

.....

v) Dates concerned:

.....

vi) Reasons for taking up this position (please indicate if your training influenced your decision):

.....

.....

vii) The typical problems/frustrations you encountered at this stage of your career:

.....

.....

.....

.....

.....

viii) To what extent did the Medical School prepare you for these problems/frustrations?

Adequately	Inadequately	Not at all
1	2	3

ix) What changes in training (if any) would you suggest to prepare future graduates for such problems/frustrations?

.....

.....

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.....

.....

x) Indicate changes (of whatever kind you deem fit) which could prevent such problems/frustrations:

.....

.....

.....

.....

.....

xi) What satisfactions did this part of your career give?

.....

.....

.....

xii) Have you ever regretted this stage of your career?

Yes	No
1	2

If yes, why? .....

.....

.....

For Office Use

22. Details of your <u>fourth job</u> after completing your internship.

i) Job description including title and rank:

.....

ii) Institution or employer:

.....

iii) Town or district concerned (and country if not S.Africa):

.....

iv) Number of years held this job:

.....

v) Dates concerned:

.....

vi) Reasons for taking up this position (please indicate if your training influenced your decision):

.....

.....

vii) The typical problems/frustrations you encountered at this stage of your career:

.....

.....

.....

.....

.....

viii) To what extent did the Medical School prepare you for these problems/frustrations?

Adequately 1	Inadequately 2	Not at all 3

ix) What changes in training (if any) would you suggest to prepare future graduates for such problems/frustrations?

.....

.....

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.....

x) Indicate changes (of whatever kind you deem fit) which could prevent such problems/frustrations:

.....

.....

.....

.....

.....

xi) What satisfactions did this part of your career give?

.....

.....

.....

xii) Have you ever regretted this stage of your career? | Yes 1 | No 2 |

If yes, why? .....

.....

.....

For Office Use

23. Details of your fifth job after completing your internship.

i) Job description including title and rank:

.....

ii) Institution or employer:

.....

iii) Town or district concerned (and country if not S.Africa):

.....

iv) Number of years held this job:

.....

v) Dates concerned:

.....

vi) Reasons for taking up this position (please indicate if your training influenced your decision):

.....

.....

vii) The typical problems/frustrations you encountered at this stage of your career:

.....

.....

.....

.....

.....

viii) To what extent did the Medical School prepare you for these problems/frustrations?

Adequately	Inadequately	Not at all
1	2	3

ix) What changes in training (if any) would you suggest to prepare future graduates for such problems/frustrations?

.....

.....

.....

.....

.....

x) Indicate changes (of whatever kind you deem fit) which could prevent such problems/frustrations:

.....

.....

.....

.....

.....

xi) What satisfactions did this part of your career give?

.....

.....

.....

xii) Have you ever regretted this stage of your career?

Yes	No
1	2

If yes, why? .....

.....

.....

For Office Use

24. Details of your sixth job after completing your internship.

i) Job description including title and rank:

.....

ii) Institution or employer:

.....

iii) Town or district concerned (and country if not S.Africa)

.....

iv) Number of years held this job:

.....

v) Dates concerned:

.....

vi) Reasons for taking up this position (please indicate if your training influenced your decision):

.....

.....

vii) The typical problems/frustrations you encountered at this stage of your career:

.....

.....

.....

.....

.....

viii) To what extent did the Medical School prepare you for these problems/frustrations?

Adequately	Inadequately	Not at all
1	2	3

ix) What changes in training (if any) would you suggest to prepare future graduates for such problems/frustrations?

.....

.....

.....

.....

.....

x) Indicate changes (of whatever kind you deem fit) which could prevent such problems/frustrations:

.....

.....

.....

.....

.....

xi) What satisfactions did this part of your career give?

.....

.....

.....

xii) Have you ever regretted this stage of your career?

Yes	No
1	2

If yes, why? .....

.....

.....

For Office Use

25. Which of the problems you listed under Questions 19 - 24 do you regard as the most important?

.....
.....
.....
.....

26. Why? .....
.....
.....
.....

NOTE: In regard to the following questions relating to private practice and hospital service AT PRESENT, please strike out those questions which do not apply to you. If you are engaged in both private practice and part-time hospital service, answer both sets of questions.

FOR THOSE IN PRIVATE PRACTICE.

27. If you are in private practice, what made you choose your present geographical area?

.....
.....
.....
.....

28. How many patients do you usually examine daily?

.....

29. Of these, how many are for repeat treatment (injections, repeat medicine)?

.....

FOR THOSE IN HOSPITAL SERVICE.

30. If you are at present in hospital service, how many patients do you examine daily (in ward/clinic)?

.....

31. How many follow-up cases do you see daily which do not involve a physical examination?

.....

For Office Use

32. How many operations do you perform per week?

.....

33. Is lack of someone with whom you can discuss medical and professional questions and difficulties a problem for you?

Yes	No
1	2

34. Why? .....
.....
.....
.....

35. Do you experience difficulties in referring patients to a hospital or specialist? (Include here problems of inadequate information fed back to you about cases.)

Yes	No
1	2

36. If yes, give details (including frequency of these difficulties):

.....
.....
.....
.....

It is the impression of the Institute for Social Research that medical training tends to overlook somewhat training about typical folk medicine practices and beliefs which a doctor will encounter among patients. (By "folk medicine" we mean non-scientific traditional (often peasant) ideas about the causation and treatment of disease. Such beliefs and practices vary from one part of the world to another, but tend to have widespread distribution.)

37. From your own experience do you think that in order to be able to understand his patients, and treat them as psychological as well as biological beings, medical training should give a doctor knowledge of and insight into "folk medicine"?

Agree Strongly	Agree	Don't Know	Disagree	Disagree Strongly
1	2	3	4	5

continued over page

For Office Use

37. (continued)

Reasons, from your experiences, for your view:

.....

.....

.....

.....

.....

☐

38. What aspects of folk medicine, if any, have you found to be of value:

Psychologically, for the support of the patient?

.....

.....

.....

.....

☐

Physiologically, in treating disease?

.....

.....

.....

.....

☐

Please specify the people or group whose folk medicine you are referring to:

.....

.....

☐

39. How do you allay the fears and anxieties of a patient who sees his/her illness in terms of traditional folk explanations only?

.....

.....

.....

.....

.....

☐

40. How do you handle the type of patient who demands an injection, regardless of the nature of his complaint?

.....

.....

.....

.....

☐

For Office Use

41. How do you handle a patient who thinks his doctor should be a diviner, and therefore should know all his complaints without asking questions?

.....

.....

.....

.....

FOR THOSE PRACTISING IN AFRICA:

42. If you are practising in Africa, what percentage of your patients suffer from:

Pellagra ..... %

Kwashiorkor ..... %

Malnutrition ..... %

Not applicable ☐

43. Typically how do you handle a Pellagra/Kwashiorkor/Malnutrition patient? Give details of any education you give and any aid/guidance you provide to improve his home conditions?

.....

.....

.....

.....

.....

44. In your opinion, did the University of Natal Medical School prepare you adequately to deal with Pellagra/Kwashiorkor/Malnutrition patients?

Yes	No
1	2

If no, give details of how improvements in training can be achieved:

.....

.....

.....

.....

.....

For Office Use

45. In your view, what are the IDEAL responsibilities of a doctor towards his patient?

1. .....
2. .....
3. .....
4. .....
5. .....
6. .....

46. Do you find that under your present day-to-day conditions you can fulfill these responsibilities?

Yes entirely	To some extent	No
1	2	3

Details: .....
.....
.....
.....
.....

47. If you could start your life all over again, and had a perfectly free choice with no handicaps, would you choose a medical career a second time?

Yes	Maybe	No	Don't know
1	2	3	4

Your reasons: .....
.....
.....
.....

48. Please indicate what your <u>future</u> plans in regard to your career are (e.g. become a G.P., specialise, take a higher degree overseas, etc.).

i) Immediate plans: .....
.....
.....

ii) Long-term plans: .....
.....
.....

For Office Use

49. The reasons for your plans:

.....
.....
.....

50. What plans did you have for your career when you left Medical School?

.....
.....
.....

51. What problems and difficulties do you experience in keeping abreast of medical developments?

.....
.....
.....
.....

52. To what medical journals do you regularly

i) Subscribe? .....
.....
.....
.....

ii) Borrow? .....
.....
.....
.....

53. How many hours a month are you able to devote to study and discussing problems with experts?

.....

54. To what extent does your Medical Association help you keep up with new knowledge?

Helps considerably	Somewhat	Not at all
1	2	3

If it does not help, do you feel it should?

Yes	No	Not applicable
1	2	3

For Office Use

Thank you for being patient, and staying with us thus far. To conclude, please provide us with some final details about yourself and your home background.

55. Your marital status:

Never Married 1	Married Once Only 2	Remarried 3	Widowed 4	Divorced 5	Separated 6

56. Did you give any bride wealth, or was there any kind of traditional gift exchange, at the time of marriage?

Yes 1	No 2

57. Type of area where you spent most of your childhood:

African rural area (Reserve)	1	
Mission reserve	2	
Farm	3	
Town	4	

58. Medical degrees and fellowships you have attained:

.....

.....

.....

.....

59. Your religious affiliation?

.....

60. Do you regard yourself as a committed or devoted member of this religious group (if any):

Yes 1	No 2	Not applicable 3

61. What is the highest educational level attained by your spouse?

.....

For Office Use

62. What is the present occupation of your spouse?

.....

63. What was his/her occupation at the time of marriage to you?

.....

64. What was the occupation of your father or guardian when you were at Medical School?

.....

65. How did you finance your medical training?

.....
.....
.....

66. If you are currently living outside the borders of the Republic of South Africa, what were your reasons for leaving?

.....
.....
.....
.....
.....

67. Do you ever plan to return to South Africa to practise medicine there?

Yes	No	Don't know
1	2	3

68. Your reasons? .....
.....
.....
.....

69. Any other comments you wish to make relevant for this survey:

.....
.....
.....
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.....

continued over page

For Office Use

69. (continued):

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Thank you indeed for completing this questionnaire. Please return it, using the enclosed addressed envelope. Stamps or international postal order to cover postage are included.

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